BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

A STUDY OF AN ATTEMPT TO PLACE IN THE COMMUNITY SELECTED CHRONIC MENTAL PATIENTS FROM TWO WARDS OF THE VETERANS ADMINISTRATION HOSPITAL, BEDFORD, MASSACHUSETTS

A Thesis

Submitted by

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CHAPTER I

INTRODUCTION

The Veterans Administration Hospital at Bedford, Massachusetts, was opened in 1928 as an 1100 bed neuropsychiatric hospital for war and peacetime veterans. Since then its facilities have been expanded, and it now has a patient population of approximately 1850.

Until May of 1944 there was but one social worker assigned to the hospital. At that time a second social worker was added; more recently the social service department has been considerably expanded. Due to limitations in the size of the social service staff, it was not until the Fall of 1946 that the policy was inaugurated of assigning each new admission to a social worker who was to be responsible for continued service to the patient throughout the course of his hospitalization. Therefore, a more nearly continuous social service contact has been maintained with patients admitted since that time than has been maintained with patients who were admitted during earlier years.

Of those patients still hospitalized who were admitted prior to the Fall of 1946, undoubtedly there are some who have lacked entirely the benefit of social service activity. It has not, in the past, been the policy to initiate social service activity in connection with these patients, except upon the specific request of the medical staff, the patient, the relatives, or some other agent. Many others have had only specific services rendered, for--except when a request has been made by the medical staff for pre-trial visit planning--it has been the general policy to return the case of the chronic or custodial care patient immediately to "inactive

status" upon the completion of a specific service. Thus a continuously active social service contact has rarely been maintained in connection with the earlier admitted patient and with the so-called chronic or custodial-care type of patient. A large majority of such patients were "inactive" with social service at the time study was proposed, in the Fall of 1947.

A: Purpose and Problems Considered

This study was undertaken by the writer at the suggestion of the Chief of the Social Service Department, upon the recommendation of the Clinical Director and the hospital Manager, to ascertain what an active social service approach to the problem of returning the chronic mental patient to the community could accomplish.

In the first place, there were the interests of the patient to be considered. Were there patients in the hospital who might now be expected to make a reasonably adequate adjustment in the community who, for one reason or another, had never been referred to social service for pre-trial visit planning? Were there other patients who might be expected to make a minimal adjustment with careful planning and manipulation of the environment to meet their individual requirements? (It was felt that there might be many reasons why individual patients among the chronic group would not have been referred to social service for planning.) A second consideration was the cost of maintaining in the hospital patients who might be placed out into the community. Another consideration was the overall problem of moving a sufficient number of patients continuously out into the community to provide beds for those constantly needing or seeking ad-

mission.

The basic purpose of this study was, therefore, conceived as an attempt to evaluate the results of an active attempt to place a selected group of chronic mental patients in the community on trial-visit status. As a project in connection with social service activity (pre-trial visit planning) it was primarily concerned with the social and emotional factors involved in the placement of such patients. Beyond this, it was hoped that the results of this study would give some indication of the desirable role of the social service department in promoting the earliest possible consideration of such patients for trial visit, as well as some indication of other desirable developments in regard to the problem of placing such patients in the community.

It was desired that the following general questions might be answered, within the limits of this study: What proportion of a sample group of chronic mental patients were considered well enough at this time to be considered for trial visit, provided adequate plans for their care, supervision, and employment (where recommended) could be made? What were the requirements for care, supervision, et cetera, among those considered for trial visit; and what were the general physical and mental limitations of members of this group which required them to have special care or supervision or which provided problems in connection with trial visit planning? What other problems were encountered in the effort to place patients from this selected smaller group? Which unfavorable factors and difficulties were overcome through case work efforts and planning; and, conversely, which were not overcome? What general conclusions could be drawn regard-

ing the overall possibility of placing such patients in the community? What limiting factors in connection with the placement of these patients might be overcome by means of new developments or changes of focus on the part of the social service department, the hospital, or the Veterans Administration?

B: Method

It was proposed by those interested in these problems that multiple studies, utilizing different groups of chronic patients, be made.* It was desired that a uniform specified procedure be utilized in selecting these groups of patients. Accordingly, the definition of the term "chronic patient" was suggested by the hospital. In connection with this study, any patient not on trial visit who had had two or more years of continuous hospitalization for a mental or nervous disorder (as of November 8, 1947) was considered to be a chronic patient. Earlier periods spent on trial visit or leave of absence (defined later) were considered as continuous hospitalization in instances where the patient was returned to the hospital within one year without having been legally discharged. While this definition is a rather arbitrary one, it was felt to be meaningful both by the hospital and by the author in connection with the purposes of this project.

The overall group of patients to be considered was also suggested by

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*A study similar in nature to this study has been currently undertaken by Miss Phoebe A. Cannon as a master's thesis for the Boston University School of Social Work.

the interested hospital authorities and Chief Social Worker. It was proposed that each contemplated project be confined to a study of patients in a selected (different) ward-building within the continued treatment division of the hospital. While the organization of the hospital will be discussed in detail later, it may be noted that this is the division within which a large majority of the chronic patients are served. It was felt that the selection of one ward-building as the unit of study would be most convenient, would provide a reasonable number of cases for study, and would provide opportunity for a close working relationship with the physician-in-charge.

The ward-building selected for the purpose of this study was selected primarily in relation to three considerations: First, it was felt that it contained a high proportion of chronic patients. Second, it was felt that few of the chronic patients from this building were receiving active service from the social service department. (It was not desired to select a building where a high percentage of active social service contacts was being maintained, as this would partially defeat one of the purposes of this study.) Third, this building did not contain the most seriously regressed patients. It was felt that at least some of the chronic patients from this building would be found well enough to be considered for pre-trial visit planning, and that the number of such patients would compare favorably with numbers that could have been obtained from other ward-buildings which met the first and second criteria.

Briefly, the process of selecting the final group of patients studied consisted of (1) selection of all patients from the building studied who

had had two years or more of continuous hospitalization; (2) elimination from this group of patients those in connection with whom there was current social service activity or for whom there had been very recent consideration of trial visit; and (3) selection by the physician-in-charge those patients (of the group remaining) whom he felt were well enough to be considered for pre-trial visit planning in connection with this study. These patients were then referred to social service for pre-trial visit planning, which was carried out according to regular procedures of the department and of the hospital.

Schedules (see Appendices A and B) were utilized by the writer in securing information concerning each patient of both the larger and smaller groups and concerning the social service activity undertaken by the worker who was responsible for pre-trial visit planning. Information was obtained from a variety of sources: from the clinical, correspondence, and social service records; from the physician, nurses, and ward attendants; from the hospital industries supervisor; and from the social worker active on each case.

The above information forms the fundamental basis of the conclusions reached in this study. However, since the material obtained was insufficient for some of the purposes of this study (see below), it has been felt advisable to make extensive use of supplementary materials in the development of this topic.

C: Limitations

In the first place, the scope of the study was limited primarily to a study of twenty-two cases with which pre-trial visit planning was at-

tempted. The study was also made during a strictly limited period of time (November 8, 1947 through March, 1948) and in relation to current activity of the social service department in connection with pre-trial visit planning for these patients. At the time of writing, social service activity was continuing in connection with several of these patients. Therefore, the possibilities of placing some of these patients had not been completely explored. In view of the above limitations, this study can by no means give final and exhaustive answers to the problems posed. It is hoped, however, that the extensive use of supplementary material has lent somewhat greater significance to the study than it would otherwise have had.

CHAPTER II

GENERAL PROBLEMS OF THE CARE AND PLACEMENT OF CHRONIC MENTAL PATIENTS; FAMILY CARE AS A COMMUNITY RESOURCE

The problems of care and of treatment posed by chronic mental illness are tremendous indeed. This study was barely begun when it was realized that these problems have many aspects extending far beyond the scope of this study. Nevertheless, it does seem well to mention some of the general problems involved, for community attitudes, administrative policies, and other such factors have been and will continue to be important determinants in what can be done for chronic mental patients.

A: General Problems of Care and Treatment in the Institution

The general practice, in this and in some other countries, of caring for chronic mental patients within institutions has had some serious disadvantages. For one thing, the cost of such care has been tremendous. A large portion of the cost quoted below, from Will O. Neil's article, is undoubtedly attributable to the care of chronic mental patients:

> More than 33,000 veterans of the last war who suffer from mental illnesses occupy about sixty per cent of all the hospital beds maintained by the Veterans Administration. The total cost of these cases from the last war already has gone well over the billion mark.[1]

In connection with this must be considered what might be termed the problem of the future. The present war has seen the mobilization of three times as many men and women as were mobilized during the last war; and

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[1] "750,000 Unwanted Men", Hygeia, 21:651, September, 1943.

there have been many more neuropsychiatric casualties.[2] In discussing the neuropsychiatric program of the Veterans Administration before the American Psychiatric Association, in Chicago, in May of 1946, Doctors John H. Baird and Daniel Blaine pointed out the tremendous responsibility which the Veterans Administration has fallen heir to. Their figures indicate that over one-half million men were discharged for neuropsychiatric disorders from the Army and Navy between January 1, 1942 and June 30, 1945. They further point out that the Veterans Administration anticipates a steady rise in the number of veterans requiring neuropsychiatric hospitalization until 1965 or 1966--approximately twenty years hence. To meet this anticipated need, a huge and exceedingly costly building program is planned.[3] Other traditional institutional problems have consisted of overcrowding, of insufficient personnel, and of inadequate facilities. Such limitations have, in most mental hospitals, severely restricted the measure of rehabilitative effort possible with chronic patients.

There remains the effect of long-continued institutionalization upon the patient to be evaluated. Hester Crutcher believes that patients' "reactions are intensified by the lack of individualization in treatment and the regimentation so difficult to avoid in institutional life."[4] As early as 1907, John E. Fish, who for a number of years was director of the family care program in Massachusetts, emphasized that during long institutionali-

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[2] Cf., Lawson G. Lowrey, Psychiatry for Social Workers, p. 314.

[3] "The Neuro-psychiatric Program of the Veterans Administration", American Journal of Psychiatry, 103:465, January, 1947.

[4] Hester B. Crutcher, Foster Home Care for Mental Patients, p.9.

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[1] [illegible]

[2] [illegible]

[3] [illegible]

zation "listlessness and apathy may degenerate into dementia from want of interest in life."[5] Surely, few who are acquainted with institutional routine would deny that such effects do occur as a result of prolonged institutionalization. The more active forms of treatment--psychotherapy, shock therapy, and the like--are eventually discontinued if ineffective. The patient whose condition has not responded to such methods of treatment continues to receive custodial care, but often little else.

B: General Obstacles to the Placement in the Community

Many difficulties have been encountered in connection with previous attempts to place chronic mental patients in the community. The most comprehensive attempt of this kind known to the writer was made at the Chicago State Hospital in the years 1930 to 1932. The question of extramural care for psychotic patients was thoroughly explored by a research group under the direction of the state alienist; and the results of this study were published by Florence P. Worthington in the Smith College Studies in Social Work, June, 1933, under the title "Suggested Community Resources for an Extensive Parole System for Mental Patients in Illinois." An attempt was made to place 290 carefully selected psychotic patients in the community. This group represented approximately nine per cent of the total hospital population exclusive of the receiving wards. While this attempt was not confined to chronic mental patients, by far the majority were chronic according to the definition utilized in the present study. These patients

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[5] "Family Care of the Homeless Insane in Massachusetts", National Conference of Charities and Corrections, 1907, p. 445. Quoted from Florence P. Worthington, infra, p. 326.

were widely varying in their degree of fitness for parole, ranging from "well fit" to "reclassified from inadvisable." (See page 287 in the source cited for a detailed discussion of the classification of these patients and of their degree of fitness for parole.)

The following difficulties were encountered in the attempt to place these patients in the community:

> The investigation showed that there were practical difficulties mitigating against parole in 269 out of the 290 cases studied. These difficulties were of the following types; more than one difficulty, of course, frequently appearing in a case: (1) the hospital economic policy of not encouraging the parole of patients who are useful workers, 132 men; (2) economic factors, 71 men, 35 women; (3) no relatives available who could assume supervision, 63 men, 35 women; (4) relatives' homes not suitable for placement of patients, 89 men, 23 women; (5) patient unwilling to leave the hospital, 3 men, 7 women.[6]

The obstacle provided by economic factors was felt to be related in part to the industrial stagnation prevailing during this period--but, in connection with thirty-one of the seventy-one men where economic factors provided an obstacle, relatives were considered unwilling to support the patient. No relative available who could assume supervision was a factor in connection with thirty-three per cent of the male patients.

In addition, relatives' homes were found to be unsuitable for the placement of the patient in forty-seven per cent of the cases of male patients. This was found to be due to physical conditions in the home which were unfavorable, to "relatives antagonistic or unqualified," or to "supervision impossible" because of infirmities or because relatives were absent from the home while employed. It seems significant that "There appeared

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[6] Supra, p. 292.

to be . . . a close relationship between the frequency of this type of obstacle and the patients' degree of fitness for parole."[7] It is to be noted, also, that lack of adequate relative resources--considering their willingness as well as their ability to assume responsibility--was a direct obstacle in over eighty per cent of the male patients considered.[8]

For further study of difficulties encountered in placing mental patients with relatives, the reader is referred to a study by Patty R. Buchanan entitled "Social Factors Which Prevent Aged Psychotic Patients from Living in the Community."[9] Suffice it to state here that, of thirty selected cases studied, in seven instances relatives were unable to provide adequate supervision; in fourteen instances emotional rejection of the patient was a factor; in seven instances there were no close relatives available; and in several instances there were crowded or inadequate living conditions or other obstacles also present.

On the other hand, there is ample evidence from these and other studies to indicate that only a relatively few custodial care or chronic mental patients have been found well enough to be placed in the community without some form of relatively close supervision. Of the 290 patients considered at the Chicago State Hospital, 162 were definitely felt to require both a sheltered environment and direct supervision in the community. An additional 112 patients were classified as fit for parole under special

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[7] Ibid., p. 314.

[8] Ibid., pp. 285 ff.

[9] An unpublished Master's Thesis, Smith College, abstracted in the Smith College Studies in Social Work, 18:146-7, December, 1947.

conditions, and most of these were felt to require some direct supervision. Only sixteen patients were classified as well fitted for parole.[10]

C: *Family Care: A Resource Proposed by Many*

Perhaps it is for the above reasons that those who have written concerning the problem of placing chronic mental patients in the community have emphasized either the need of or the values of foster family care. This has been true without exception of the authorities consulted by the writer. Moreover, *in every instance known to the writer where significantly large groups of chronic mental patients have actually been placed in the community, some form of family care has been utilized*. For these reasons--and because many difficulties were encountered in connection with the placement of the patients studied in this project--it seems advisable to consider this resource in some detail here.

Hester Crutcher, Director of Social Work for the Department of Mental Hygiene in New York and a foremost American authority on family care, has this to say regarding the function of family care:*

> In recent years there has been an increasing interest in the development of family care for mental patients in the United States. This is the term used for placements, made by institutions, of quiet, well-behaved mentally ill or mentally defective patients for care in homes other than their own. Such patients are no longer in need of the highly specialized services offered by the institutions . . . . These are patients who, because of their mental condition, are not able to maintain themselves by their own work or able to carry on their own affairs sufficiently well to be placed in the community even with the supervisory help of local social agencies.

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[10] Worthington, *op. cit.*, p. 287.

* *Note*: In her book, *Foster Home Care for Mental Patients*, she discusses the entire problem of family care quite thoroughly. See bibliography.

> The objectives of family care are to give patients the advantages of home life and as much freedom in their living as is compatible with their mental condition, and to free hospital beds for patients who, because of acute mental symptoms, are more in need of the services of the institution . . . . Furthermore, the response of the patients to the individual attention which they receive as members of a family group shows the desirability of this type of care for patients . . . .
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> In most of the states where family care is utilized, it has developed along two lines. First, it has been found that the continuous-treatment type of patient who lives comfortably in the world that he has created for himself responds well to family care. This does not mean that he recovers, for his illness is so deep-seated that he may never be well again. It means, however, that the patient responds to the individual attention that he receives in the home and usually becomes a happier, more useful person. If the chief objective of family care is to relieve the congested wards of a hospital, these patients can be placed in sufficient numbers to accomplish this end.
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> For other patients, family care is used as a carefully-worked-out therapeutic procedure in the hope that their convalescence will be hastened by this treatment. When family care is used therapeutically, the patient usually has many emotional needs to be met by a carefully selected family placement. In addition to this, the patient may also need opportunity to utilize old skills or to learn new ones, or to develop interests in activities which are available only outside the institution. This method of treatment has been found particularly advantageous for patients whose own family situations have been unsatisfactory, or for those who have no interested relatives, as it gives the patient the support he needs while he is convalescing and reestablishing his community ties.[11]

The extent to which family care has been utilized in some countries is truly remarkable. In 1937 there were approximately 3600 mentally ill persons living under supervised family care in Gheel, Belgium, alone.[12] "The 1930 Annual Report of the General Board of Control for Scotland indicates that 1124, or thirty-four per cent of the total number of insane,

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[11] "The Role of the Social Worker in Family Care of Mental Patients," Smith College Studies in Social Work, 14:118-19, 1943.

[12] Crutcher, *loc. cit.*

Were cared for in private dwellings."[13] In 1940, approximately 4300 patients, or four per cent of the total number of insane, were in family care in Germany.[14] Several other European countries are also utilizing family care.

In the United States:

> Family care of mental patients is not a new venture . . . . In Massachusetts patients have been placed in homes since 1886, but it is only in the past decade that increasing interest has been shown in the program. At the present time [1943] eleven states are using Family Care Placement . . . . There are now over 3000 mental patients in the United States living in family care under the close supervision of institutions to which they were committed for treatment. The great majority of these are in the states of New York and Massachusetts.[15]

Since the great majority of mental patients placed in family care have been of the custodial-care type, family care seems to stand alone as a community resource adaptable to the placement of large groups of chronic mental patients.

In addition, great satisfaction with family care has been expressed by most of those who have been instrumental in developing the programs; and many advantages are claimed for it. Doctor F. Sano, Medical Director of the Colony of Gheel, Brussels, Belgium, strongly emphasizes the quality of supervised freedom and the therapeutic aspects of family care: "Occupational therapy, foreseen long ago . . . has spread widely; the system of

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[13] Helen M. Crockett, "Boarding Homes as a Tool in Social Case Work with Mental Patients", Mental Hygiene, 18:192, April, 1934.

[14] C. E. Thompson, "Family Care of the Insane", American Journal of Psychiatry, 91:338, September, 1934.

[15] Crutcher, loc. cit.

supervised freedom becomes its counterpart."[16] At the same meeting of the First International Congress on Mental Hygiene where Doctor Sano's report was read, Doctor Ernst Bufe, Director of the County Hospital and Sanitarium, Allenberg, East Prussia, discussed fifteen advantages of family care. Among these many advantages, he felt that it saves the patient from the "mental damage done by prolonged institutionalization"; "results in quicker social readjustment"; guarantees individualized treatment; offers "numerous occupational possibilities unequalled in naturalness and therapeutic value"; is a "natural bridge to parole and discharge"; is the "cheapest treatment in the world"; and has applicability to many types of patients.[17]

Following two years of experience with family care in a state hospital, Doctor Newton Bigelow concludes that:

> Over and above all other considerations . . . family care is an efficacious form of therapy rather than a mere custodial procedure. A definite abatement of psychotic symptoms is the rule . . . . The positive effect of the objective attitude of the foster family towards the patient's illness may be contrasted sharply with the subjective attitude of his own family . . . . The value of foster family care following insulin therapy, with reference to potential old age pensioners, those in whom there is not prospect of parole, in young individuals to avoid possible chronic institutionalization, and in certain apparently hopeless cases from a social standpoint, has been illustrated [by several excellent case examples] . . . . The continued expansion of foster family care seems to be definitely indicated.[18]

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[16] F. Sano, "The Care of the Insane Outside of Institutions", Proceedings of the First International Congress on Mental Hygiene, 1:379, 1932.

[17] Ibid., p. 393

[18] Newton J. T. Bigelow and Eva M. Schied, "The Therapeutic Promise of Foster Family Care for the Mentally Ill", Psychiatric Quarterly, 13:30, January, 1939.

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Of still greater significance, perhaps, the Group for the Advancement of Psychiatry has gone on record in these terms:

> Family Care, which is the placement of patients with families other than their own for care and treatment, is recognized as a major development in the care of psychiatric patients. It is deplorable that this extremely promising procedure has not been more widely employed. [19]

For the above reasons, it seems particularly pertinent in connection with this study to consider the types of patients which have been satisfactorily placed in family care. It seems especially significant that many of the patients who have been placed in family care, both in America and abroad, have been quite ill. Many have been markedly regressed, many have been actively delusional or hallucinated, some have been entirely mute, many were tried in family care after numerous failures with attempts at regular parole, and numerous patients have been mentally defective or deteriorated. Hester Crutcher describes remarkable improvement in a woman patient who had not spoken a word for seven years and who was considered to be entirely oblivious of her surroundings. Another patient described spent much of her time looking for devils. Another was a physically infirm and deteriorated general paretic who was untidy (at first) and difficult to handle. She makes a startling statement: "The fact that a patient is so psychotic that he cannot possibly utter a coherent or lucid sentence has in no way interfered with the adjustment he makes in a home."[20]--provided, of course, that certain precautions are observed in placement.

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[19] The Psychiatric Social Worker in the Psychiatric Hospital, report No. 2:4, January, 1948.

[20] Foster Home Care for Mental Patients, p. 48. See also pp. 6 and 128.

Patients placed in family care have usually fallen into one of the following general categories:

> 1. Those who are so completely absorbed with their own psychotic ideas that they are comfortable anywhere and what goes on around them is not of vital importance . . . .
>
> 2. Those who because of old age and its degenerative processes are confused and at times irritable and difficult . . . .
>
> 3. Those whose dissatisfactions with hospital treatment may be decreased with family care.
>
> 4. Those whose paranoid trends would make it impossible for them to adjust among former associates.
>
> 5. Those who, though apparently in good condition, have never been able to adjust outside the hospital for more than very brief periods. In this group are persons who have known nothing but institutional life . . . some alcoholics, and those whose family situations are major factors in the psychosis.
>
> 6. Those whose recovery will be hastened by family care . . . for whom there might be danger of becoming completely institutionalized should they remain in the institution over a long period of time . . . .[21]

In connection with the mental and physical diagnoses, she concludes:

> The important factor in selection is not the diagnosis, but the degree of disturbance and its effect on the patient and others . . .
>
> It has been found that a chronic physical disability is not a contraindication for family care.[22]

However, it has been found best to observe certain precautions as to the type of patient placed, particularly when first establishing a program of family care. Pollock suggests that:

> . . . until a system of family care is well established, it probably would be best to place only tractable patients beyond

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[21] Ibid., pp. 48-9.

[22] Ibid., p. 50.

> middle age. These . . . would include quiet schizophrenic, chronic manic-depressive and other patients who have established a more or less settled routine and are not trouble-makers . . . . In instituting a system of family care it is highly important that the patients placed out would not be disturbing factors in the community.
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> In the mentally diseased group types not suitable for family care would include the following: (a) Patients that need constant medical or nursing attention. (b) Patients suffering with mild or acute mental disorders who are likely to make prompt recovery. (c) Patients who are disturbed or suicidal. (d) Patients that are quarrelsome, contentious or have pronounced delusions of persecution. (e) Patients with marked erotic tendencies. (f) Patients who have convulsions. (g) Patients that are suffering with infectious or contagious diseases.[23]

The problems of locating and selecting foster homes are generally considered to be more complex than those of selecting the patients. Hester Crutcher, Horatio M. Pollock, Helen M. Crockett, and others have discussed these problems at length. It is not felt to be within the scope of this study to discuss these problems in detail.

The cost of family care does need to be briefly considered here, however. In Massachusetts, the maximum amount allowed by the Commonwealth for boarding home care was only $5.50 per week in 1941. It is now $10 per week. According to Mrs. Olive Dorman, Social Service Supervisor of Family Care at Worcester State Hospital, the current high cost of living (combined with other abnormal conditions of the post war period) has made it difficult to locate homes at even this increased rate. Patients selected have usually been chosen partially upon the basis of ability to do some useful work. In a small number of boarding home placements made by

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[23] Horatio M. Pollock, "Practical Considerations Relating to Family Care of Mental Patients", American Journal of Psychiatry, 92:561, November, 1935.

the Bedford Veterans Hospital, the amount paid[24] has varied considerably, according to the physical and mental condition of the patient, his ability to work, and funds available in individual cases. In some instances, patients have earned their entire care; in other instances, over twenty-five dollars per week has been paid. Approximately twenty dollars per week was felt to be the average amount paid for patients unable to do much work.[25] It has been the experience of the state hospitals that the lower rate is more satisfying to foster families when more than one patient can be placed in the home.

A discussion of many other practical problems in connection with the development of family care programs must be omitted here.

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[24] It is to be noted that the Veterans Administration does not assume responsibility for meeting the costs of boarding home care. Payments are usually made directly by the patient's representative and from the patient's funds.

[25] Source: Mr. John Malloy; Case Supervisor, Social Service Department, Bedford Veterans Hospital.

CHAPTER III

THE HOSPITAL SETTING; DESCRIPTIVE DEVELOPMENT OF THE PRESENT PROJECT; SOCIAL SERVICE AND PRE-TRIAL VISIT PLANNING

A: The Hospital

As noted previously, the Bedford Veterans Hospital now has a patient population of approximately 1850. As of June 30, 1947, this population included 536 male veterans of World War II. It also included 1243 male veterans of World War I and of military service during other periods, including peacetime. The female population has been rather small. While the homes of the majority of the patients are within a radius of fifty miles of the hospital, some patients do come from neighboring states as well as more remote areas of Massachusetts. Between July first of 1946 and June thirtieth of 1947 there were 568 admissions and 545 discharges. Veterans of World War II make up somewhat more than half of the new admissions and a still larger percentage of the discharges. The number of patients on trial visit has varied during recent months from around 220 to around 250. Patients come from all walks of life and all cultural patterns; and the parents of more than one-half are foreign born.[1]

The medical services of the hospital are divided into the Admissions Service, the Acute-Intensive Treatment Service, and the Continued Treatment Service; also there is the Woman's Division, which has a complete medical service. The Continued Treatment Service comprises by far the

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[1] Sources: Hospital statistics; also Rebecca Glasmann, "A Study of the Student Training Program of the Veterans Administration Hospital, Bedford, Massachusetts", pp. 19-20.

largest division of the medical services and serves a great majority of the hospital patients--particularly those who are either partially regressed, deteriorated, or more or less recovered from the acute stage of their illness. A high proportion of the World War I patients are housed in Continued Treatment wards.

Patients housed in the Continued Treatment wards are given the benefit of psychotherapy, shock treatment, occupational therapy, et cetera, whenever it is felt that they can be benefitted. But most of those patients who are partially regressed or deteriorated and whose illness is considered chronic or static receive what is commonly referred to as custodial care.

Doctor Bernard Schegloff of the hospital medical staff described the types of patients to be found in the Continued Treatment wards as follows: One general group of patients consists of the considerably regressed patients and of the serious psychopaths, alcoholics, et cetera. A second group consists of patients in the process of recovery and of progression from one building to another toward greater freedom and, perhaps, eventual discharge. In general, this is a younger group of patients containing many World War II veterans. A third and larger group consists primarily of middle aged and elderly patients, partially regressed, but sufficiently well to be engaged in various work details about the hospital.[2]

Patients from this latter group make up the major portion of the group of patients considered in this study. Such patients no longer re-

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[2] Source: Comments on custodial care by Doctor Bernard Schegloff at a General Staff Meeting of the Veterans Administration Hospital, Bedford, Mass., in January of 1948.

ceive any great amount of active psychotherapy. Many go about their daily tasks in the hospital industries (which include all forms of more or less routine activity in connection with the operation and maintenance of the hospital) or on the wards in an uneventful fashion over long periods of time. Some receive training in the occupational therapy division of the medical rehabilitation department. Most attend at least some of the hospital recreations. Some have full or limited privileges to go about the hospital grounds unattended, and others do not.

Patients are generally referred by the ward physician to social service for pre-trial visit planning when it is felt that they are well enough to be considered for trial visit.[3] However, patients are frequently allowed home with interested relatives for short periods when such relatives request to have the patient at home for a while and when the patient is considered well enough to have such a privilege. Such visits are limited to two weeks in duration and are called leaves of absence. Occasionally a patient is allowed to remain at home longer at the relatives' request, and in these instances the status of the patient often is changed directly to trial visit status. Often in the past, therefore, the placement of unrecovered chronic patients upon trial visit has depended upon the interest

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[3] It should be noted at this point that trial visit is a procedure provided for in the Massachusetts General Laws which allows patients to be released from the hospital into the community for a period of one year before the discharge becomes absolute. The patient may be released in the custody of any responsible individual or agency or by himself, and he may be readmitted at any time during the year without a new court commitment. If desired, a patient may be kept on trial visit status for an indefinite period, provided he is returned to the hospital for one day prior to the expiration of any year on trial visit.
Source: Mass. G. L., Ch. 123, s. 88.

and initiative of the relatives in requesting to have the patient at home; in other instances it has depended upon their willingness to accept the patient.

B: Descriptive Development of This Project and Study

This paper is descriptive of an effort on the part of the Social Service Department to work intensively with a group of chronic patients selected for pre-trial visit planning regardless of relatives' interest. Since development of this project has been partially described in the introductory chapter of this paper, the reader is referred to this chapter for a description of the basic plan of procedure. The criteria applied in the selection of the ward building have been described there. It may be added here that this building contains two wards--both of which were considered in connection with this study--and has a capacity of one hundred and sixty-four beds (largely occupied at all times). It is a semi-privilege building, by which is meant that many of the patients have the privilege of going about the hospital grounds, or in some instances a restricted portion of the grounds, unattended. It is utilized primarily for partially regressed chronic patients and for partially recovered patients in the process of advancement from one building to another toward eventual discharge. Many patients have been discharged directly from this building; many have been sent on to other buildings permitting greater freedom; and some have been in continuous receipt of care in its wards for years.

A review of the case records of all the patients in this building on November 8, 1947, produced a group of one hundred and twelve patients who

met the definition of chronic mental patient. Seven patients were excluded because social service workers were found to be currently providing service or because there had been a recent effort at trial visit planning. Three more were later excluded because trial visits were granted them directly from leaves of absence before this project had been completely organized. This left a group of one hundred and two patients formally considered in connection with this study.

Twenty-four patients were then selected by the physician from this larger group and referred by the writer to social service intake for assignment to individual workers and for pre-trial visit planning. However, one patient became too disturbed to be considered for trial visit immediately and another patient was later felt to have regressed so badly that the physician advised against contacting his relatives. Trial visit planning was, therefore, actually undertaken only with the remaining group of twenty-two patients. Only this group of patients is considered in the following pages.

These patients were considered as possibly able to adjust in the community if adequate supervision and care and an accepting environment could be provided for them. However, the physician felt that the great majority would be able to adjust at only a minimum level in a sheltered environment. He repeatedly stressed that the patients selected were not well and that relatives should only be encouraged to accept them when definite willingness was displayed.

At the time of selection, the physician made brief recommendations to the writer concerning the needs of each patient, and these recommendations

are included in the case studies presented, as are any more detailed recommendations which were later given to the individual workers active in connection with pre-trial visit planning.

In completing the schedule utilized in connection with these case studies (see Appendix B) the writer himself consulted the principal sources of information concerning each patient. (See Chapter I, page six.) The information obtained by the writer was then, in most instances, discussed with the case workers, who consulted many of these same sources of information in connection with their efforts at pre-trial visit planning. The information utilized in this study which has to do with the actual effort at trial visit planning was obtained either in conference with the individual workers or from their own recording of their observations and activities.

C: Description of the Social Service Department and of the Function of the Social Worker in Pre-Trial Visit Planning

At the present time, the Social Service staff consists of a Chief Social Worker, two Case Supervisors, six Social Workers, seven Student Social Workers, and the clerical staff. The students are second year students from the three schools of social work in Boston; and the period of their placement corresponds approximately with the two semesters of the school year, varying somewhat with the requirements of the individual schools. The Chief Social Worker does not generally work directly with the patients or their families and the two Case Supervisors carry a limited caseload. During the school year, the students carry an average of twelve to fifteen cases each. However, two of the social workers who

function as field work supervisors carry a considerably reduced caseload during this period and do not as a rule make field visits. The remaining four social workers, therefore, have a heavy responsibility for actual case work services, particularly for trial visit supervision and other types of service involving field visits. While actual service may not be given on each of the following cases each month, an average of approximately six hundred cases is carried by the department on "active status" each month. This number includes the cases of all patients who are on trial visit, of all patients admitted each month, and of patients in the hospital to whom services are being rendered. During the past twelve months, services have been given to approximately forty-five newly admitted patients each month, which includes practically all of the patients admitted. Visits are made or reports obtained regarding the approximately 220 to 250 patients on trial visit at least once every three months, and in many instances a more frequent contact is maintained, particularly during the earlier months of trial visit.[4]

The Veterans Administration regulations outline the basic functions of the social service department and of the social worker as follows:

> The department will be responsible for (1) collaboration with physicians in the social study and treatment of the personal circumstances related to veterans' health, recovery, community adjustment, and reduction of disablement; (2) cooperation with adjudication, insurance, and vocational rehabilitation authorities, and the chief attorney in securing data pertinent to the veterans' and other beneficiaries' maximum utilization of the benefits administered by those

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[4] Sources: Hospital Statistics and information obtained from the Case Supervisors in the Social Service Department.

[illegible]

[illegible]

> [illegible]

[illegible]

> authorities; (3) completion of field examinations when the nature of the contacts, the information desired, or the interests of economy of travel make it advisable to utilize the services of a social worker . . . . (4) the establishment of coordinated, useful working relationships with private and public social and health agencies in advancing the hospital and community adjustment of veterans; (5) . . . . (6) cooperation in research projects aimed at improving Veterans Administration health services to veterans.
>
> (B) The social study and treatment undertaken whether in the out-patient department, the hospital, or the field will be in close collaboration with the physician responsible for the examination and treatment of the veteran, to insure that it constitutes an integral part of the physician's over-all plan for that veteran. The individual social worker is responsible for the complete harmony of the social measures taken with the physician's program. This requires frequent conferences between the physician and social worker, as well as precise social work entries in the veteran's file . . . .[5]

In connection with the specific process of pre-trial visit planning, two principal functions of the social worker are described as (1) the determination of the home conditions and environment to which the patient will be going and (2) preparation of the family for the patient's arrival. If the patient is not to live with his own family, their acceptance and approval of the hospital plan must usually be obtained. If the patientis to be returned home, the full cooperation of the family must, of necessity, be secured. These functions are generally carried out by the hospital social worker. However, when a patient's relatives live outside the area directly served by the hospital social worker, these relatives are usually contacted by a social worker from the nearest regional office of the Veterans Administration. (Occasionally the aid of another community agency must be utilized.) In these instances, a written request for assistance

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[5] "Regulations and Procedures", pp. 191-94R.

in connection with pre-trial visit planning is sent out by the hospital social worker. Such a request includes a description of the patient's mental condition, his adjustment in the hospital, the type and amount of supervision he will require, the type of plan for him which is considered most suitable, and other information useful to the assisting agency. If the assisting agency is a regional office of the Veterans Administration (as it usually is) the functions requested are carried out by the social worker from this office and a detailed report is returned to the hospital. This report usually contains information concerning the relatives' attitudes toward the patient and toward the plan proposed. If it is desired that the patient live with the family, the report usually contains information concerning home conditions and concerning the family's ability to give proper supervision. Other pertinent data is also included concerning the family or community situation and concerning the worker's own activity. Whether or not the assistance of a regional office social worker is requested, the full initiative and resourcefulness of the worker are to be utilized in preparing the home and community for an intelligent, favorable reception of the patient.[6]

In addition, if planning is to be soundly based, the social worker must have as much information as possible concerning the patient's hospital adjustment. Helen Hill suggests that the nurse on the ward, the attendants, and other personnel to whom patients are assigned are in a position to give much valuable information concerning the patient's personal-

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[6] Procedures to be utilized in connection with pre-trial visit planning are described in detail in the manual of "Regulations and Procedures", pp. 195-6R.

ity, peculiarities of behavior, habits, and interests.[7] At the Bedford Veterans Hospital, such information is generally obtained from these personnel.

Other resources within the Veterans Administration are also frequently utilized in connection with trial visit planning. It is sometimes necessary to establish a guardianship, which is effected through the office of the chief attorney at the appropriate Regional Office. The Adjudications Division may also be utilized in connection with reconsideration of the patient's pension or compensation award. The Contact Division, the Mental Hygiene and Medical Clinics, the Vocational Rehabilitation Division, and the Education and Training Division in the Regional Office are frequently called upon for services in connection with pre-trial visit planning.

As a special aspect of pre-trial visit planning, the policy of the Veterans Administration and the role of the psychiatric social worker in connection with the placement of patients in boarding home care should be briefly considered. At the present time, Veterans Administration hospitals (including this hospital) follow the practice of placing a limited number of patients in boarding homes when this seems therapeutically indicated and when the patient has funds to cover expenses.[8] However, according to Doctors Blaine and Baird in their discussion of the neuropsy-

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[7] "The Function of the Psychiatric Social Worker in the Hospital", <u>United States Veterans Bureau Medical Bulletin</u>, 8:282, January-December, 1931.

[8] Jack H. Stipe, "The Veterans Administration Social Service Program", <u>Public Welfare</u>, 5:52, March, 1947.

chiatric program of the Veterans Administration, the Neuropsychiatric Division has adopted the policy of developing "a program of foster home care for selected psychotics and an extension of the trial visit program generally." This policy, among others, is being realized "as rapidly as circumstances permit."[9] No funds have been made available to cover maintenance costs for patients placed in family care at this time, however. The role of the psychiatric social worker in connection with family care placements is very briefly described in a recent Group for the Advancement of Psychiatry report, "The Psychiatric Social Worker in the Psychiatric Hospital:

> In this instance, the social worker is responsible for assisting the hospital in locating foster families. He should make studies of the home to insure meeting the patient's need for care. He should select the home for the patient after consultation with the psychiatrist and be responsible for arranging the placement of the patient. This would involve working with the patient in his preparation for the placement, as well as with the foster family, and, if such exists, with members of the patient's own family . . . .[10]

Finally, both Jack H. Stipe and the Group for the Advancement of Psychiatry--along with many others--have emphasized the importance of viewing pre-trial visit planning as a continuous process, beginning with the admission of the patient to the hospital. The Group for the Advancement of Psychiatry have particularly emphasized this:

> . . .the social worker must be concerned with all aspects of the patient's relationships within the hospital as well as to his family and community. Such activity on the part of the social worker reaffirms the idea that the hospital's responsibility is limited in time

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[9] Op. cit., p. 463. This was as of May, 1946.

[10] Op. cit., p. 9.

> to a period of more specialized treatment, and that treatment carries over into the community. The use of the term "preparing the home" is inappropriate since it implies a previous surrender of family responsibility, and it is a clear-cut function of the social worker to prevent any such disruption in the continuity of the family-patient relationship. For the family, the mentally ill patient often becomes a frightening stranger. The worker can help the family with this problem of disturbance of familiarity so that they can accept him back as they find him. In such social work activity there is real promise of reducing length of hospital stay as well as avoiding a good deal of unnecessary human suffering.[11]

The relationship thus established by the worker with the patient and with the family through such contacts is considered by many to be an important factor in determining later success in returning the patient to the community.

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[11] Ibid., pp. 3-4.

CHAPTER IV

PRESENTATION OF CASE DATA AND PARTIAL PRESENTATION OF CASE MATERIALS

A: The One Hundred and Two Patients

The general types of patients to be found in the building selected for study have been previously described in Chapter III. Therefore, the total group of one hundred and two patients who met the general criteria for inclusion in this study will be most briefly considered here.

The majority of these patients were veterans of World War I. Approximately one-fourth were veterans of World War II. The remainder were veterans of other periods of service ranging from recent peacetime service to the Spanish-American War. Dementia praecox was the primary diagnosis in eighty-four of the one hundred and two cases. Among the remaining eighteen patients the diagnosis varied widely. There was only one patient diagnosed psychosis with cerebral arteriosclerosis, although some of the patients suffered general arteriosclerosis. There were no patients diagnosed senile psychosis.

The age range of fifty to fifty-nine years included fifty-one of the one hundred and two patients--exactly one-half of the group. By contrast, there were only eleven patients under thirty. There were only twenty-six patients under forty (including an additional fifteen whose ages ranged from thirty to thirty-nine years). There were eleven patients in the group from sixty to sixty-nine years of age; none older. The disproportionate number of patients with ages from fifty to fifty-nine years is undoubtedly due to the presence of the large number of World War I vet-

erans in the group. The length of hospitalization varied greatly, ranging from two years to thirty-six years.

The fairly low proportion of patients ages sixty and over and the near absence of such diagnoses as psychosis with cerebral arteriosclerosis and senile psychosis may in part be due to the fact that patients requiring considerable physical care tend to classify on other wards. Also, the Bedford Veterans Hospital may have a somewhat lower percentage of such cases than the state hospitals. For one thing, the majority of World War I veterans are still in their fifties. Other factors, such as admission policies, may also be involved.

B: The Twenty-two Patients Selected for Pre-trial Visit Planning

While this group of patients represents a sub-group selected as previously described from the above group of patients, it would seem desirable to describe the characteristics of this group in considerably greater detail.

Since the Bedford Hospital is a veterans' hospital, it is perhaps pertinent to indicate the general period during which these patients served in the armed forces. Five of these patients were veterans of World War II. Three served during peacetime between the two world wars. Twelve served during World War I. One served during peacetime prior to World War I; and one was a Spanish-American War veteran. Some of the veterans of the world wars also had peacetime service.

The present ages of these patients are described in Table I, below. As may be noted from Table I, twelve patients, or more than one-half of the number considered for pre-trial visit planning, were fifty years of

TABLE I

AGE WHEN CONSIDERED FOR PRE-TRIAL VISIT PLANNING

Years	Number
60-69	6
50-59	6
40-49	4
30-39	4
20-29	2
Total	22

age or older. Roughly, one-fourth were sixty years of age or older. Only two patients were under thirty years of age. Eight patients were within the age range of thirty to forty-nine years inclusive. The writer does not know why six of the eleven patients ages sixty to sixty-nine were found suitable for pre-trial visit planning while but the same number of the fifty-one patients ages fifty to fifty-nine were found suitable.

The length of hospitalization for the present illness is described in Table II, below. Table II is largely self-explanatory. It might be well to point out, however, that the six patients who have had the shortest period of hospitalization--two to four years--are the six World War II veterans included in this group. The class interval "20 and over" includes five patients hospitalized between twenty-one and twenty-six years and one patient hospitalized thirty-six years. Seven patients of the twenty-two have had fairly extensive periods of hospitalization not considered in connection with Table II, since Table II does not include earlier periods of hospitalization involving a complete discharge from hospital supervision.

TABLE II

LENGTH OF HOSPITALIZATION FOR PRESENT ILLNESS

Years*	Number
2 - 4	6
5 - 9	2
10 - 14	5
15 - 19	3
20 and over	6
Total	22

*Note changes of class intervals.

The diagnoses of the twenty-two patients are given in Table III, below.

TABLE III

DIAGNOSIS

Diagnosis	Number
Dementia praecox, hebephrenic type	7
Dementia praecox, paranoid type	5
Dementia praecox, other types	5
Dementia praecox, with chronic alcoholism	2
Psychosis traumatic, post traumatic mental enfeeblement, chronic alcoholism	1
Psychosis with cerebral arteriosclerosis	1
Psychoneurosis, reactive depression	1
Total	22

It is to be noted that nineteen of the twenty-two patients selected had a basic diagnosis of dementia praecox. One reason for this is that the chronic schizophrenic patient is so often a shy, withdrawn, harmless individual, living more or less contentedly in a world of his own creation. By contrast, the unstable psychopathic patient, some alcoholics, and the aggressive or argumentative patient are more difficult, in general, to supervise; likewise the patient with strong tendencies toward depression, who might harm himself. Only a limited number of paranoid type schizophrenics were included. For one reason, this type of patient is more given to unpredictable behavior than the other types of schizophrenics. They were considered by the physician somewhat more prone to act out what their voices tell them to do than another type of schizophrenic, who may be content to simply carry on a conversation with his voices or to ignore them. Secondly, many of these patients tend to be suspicious and do not get along well with other people.

C: Case Study of the Patient Who Was Placed on Trial Visit

Only one patient has been placed on trial visit from the group of twenty-two. The case of this patient is described below:*

CASE NO. I

> E. is a twenty-seven year old, single veteran of World War II who has been hospitalized slightly over three and one half years. He carries a diagnosis of dementia praecox, hebephrenic type. He became ill during military service and was quite disoriented and hal-

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*Note: It has not been considered within the scope of this study to evaluate the activity of the social worker as an end in itself. It is proposed to analyze the data of this study only in relation to the purpose and general questions outlined in Chapter I.

lucinated when admitted to the hospital early in 1944. Since that time he appears to have shown gradual improvement. At the time of a recent psychiatric examination he was described as a quiet and cooperative patient who was simple and childish but neat and tidy. He heard voices occasionally which "did not bother" him. He was coherent and relevant in his answers; but he was disoriented for time. He has been an apathetic patient who has shown no initiative. He was formerly assaultive and threatening towards his mother; but he has not recently demonstrated such tendencies. The physician felt that he might be able to adjust at a minimum level in a family environment capable of providing him with good supervision. It was felt advisable for someone to be present in the home with him the major portion of the time.

On the ward, E. has been asocial and rather mute but fairly cooperative. However, at times he has been impulsive though not seriously aggressive, and at other times he has been somewhat resistive. He has required patience and close supervision. For a brief time he enjoyed working on a grading detail, did well, and seemed to enjoy it, but his mother objected to the type of work he was doing. He has since been disinterested in other assignments.

He has had several short leaves of absence to the home of his parents during 1947 and has apparently adjusted at about the same level as in the hospital. He spent most of the time playing the piano and reading. He also helped with household tasks. He was not threatening and caused no trouble. His mother returned him on one occasion when the leave of absence was to have been changed to trial visit, stating that she was concerned that he had not eaten well and had not talked much. During earlier, longer periods at home he appears to have become resistive and to have verbally threatened her.

When interviewed by the social worker, he was unresponsive, apathetic, and listless. He shrugged his shoulders and answered in monosyllables. He gave the impression of having a somewhat negative attitude toward going home and seemed indifferent toward leaving the hospital.

The family consists of the parents and two unmarried sisters at home. When interviewed, Mrs. E. was found willing to try him on a trial visit. Supervision was felt to be adequate and there were many favorable factors in the home situation. However, Mrs. E. is considered in the past to have expected her son to adjust at a more adequate and more nearly normal level than he is capable of. She is felt to have been both over-protective and over-controling, to have watched him too closely, and to have tried too hard to get him to eat, talk, and take care of his physical needs more adequately.

An effort was made by the social worker to further interpret

> E.'s needs to the mother, and he has been placed on trial visit in his own home. The social worker was doubtful, however, if the interpretations given Mrs. E. were sufficient to have given her a significantly increased acceptance of her son's limitations.

. . . .

This case would seem to illustrate that an unrecovered mental patient, such as E., may have very definite individual requirements for patient, objective, and accepting supervision. It particularly seems to illustrate the need of finding an environment in which such a patient can be accepted at the level at which he is able to function. On the other hand, it appears to illustrate that even a very ill patient, such as E., may possess the capacity for adjusting in the community (at a minimum level) when such a placement can be obtained. This conclusion is based upon the physician's recommendations, upon the fact that he actually has been placed on trial visit, and upon the fact that he has adjusted fairly satisfactorily in the community for numerous short periods. (This conclusion is somewhat strengthened by the fact that E. appears less well mentally than many of the patients considered in connection with this project.)

In spite of the fact that there were considered to be sufficient strengths in the home to warrant placing E. there, this case also seems to indicate that it may be very difficult for the family to be objective in their attitude toward the unrecovered patient and to accept him at a level at which he is able to function. The existence of a family care program at the hospital might have made possible--temporarily or initially at least--the provision of an accepting environment and adequate supervision for E., free from some of the unfavorable factors present in the

home situation.

D: Case Studies of Patients for Whom a Plan for Placement Has Been Created

With three additional patients, a plan for placement has been created which it appears can be effected in the near future, and which shows reasonable promise of meeting the patients' individual needs. These cases are described below:

CASE NO. 2

> D. is a single, thirty-three year old veteran of World War II who carries a diagnosis of dementia praecox, hebephrenic type. He has been hospitalized for five years. Medical reports describe him as apathetic and emotionally unresponsive (affect very flat). He is disinterested in any type of activity and sits idly on the ward. He hears apparently harmless voices and mumbles to himself considerably. He has been quiet and cooperative and has been no problem in care. He is not considered well enough to go about the hospital grounds unattended; and he has no work detail. Recent change in his mental condition has been unapparent. The physician felt that he might be able to adjust at a minimum level in a family environment. He would require general supervision of his daily activities similar to that prescribed for the preceding patient.
>
> In D.'s case, both a married sister and a married brother have shown interest in him and have taken him out of the hospital on leaves of absence. D., in return, appears to have maintained a positive feeling toward his family. Although D. has been listless, apathetic, and actively hallucinating (talking with his voices) in the homes of his relatives, both families have apparently been quite accepting of this behavior. The brother once kept D. successfully for a period of six months, but was not at this time able to provide adequate supervision. However, the sister and her husband were both found by the social worker to be accepting toward D. and quite willing to assume responsibility for his care. Their two married sons were also interested and agreed to provide odd jobs and recreation for D. The sister is home days; and D. has sufficient funds to provide for his own needs.
>
> The plan has accordingly been made for D. to go on trial visit to the home of his sister upon the completion of redecorating in her home.

. . . .

This case would appear again to illustrate that a seriously regressed but harmless patient may adjust satisfactorily outside of the hospital in an accepting family environment. D. appears to have adjusted to the satisfaction of both his relatives and the hospital during earlier periods on trial visit and leave of absence. Yet, he has been hallucinated, idle, and apathetic in the hospital. On the positive side, he has been a quiet and cooperative patient who has presented no problems of care or supervision in the hospital. In view of the relatives' interest, it would appear that he might have been placed in the community at an earlier date had an active exploration of relative resources been undertaken.

CASE NO. 3

> G. is a forty-six year old, single veteran of peacetime service who has been hospitalized for nineteen years. His diagnosis is dementia praecox, paranoid type; and his condition appears to have remained unchanged for some time. Medical reports state that he is quiet, cooperative, and friendly. He is well oriented and responds to questions "quite normally." He feels physically sick and weak (although his physical condition is good) and has accepted no work detail because of this feeling. No hallucinations or delusions were elicited. About the ward he spends his time aimlessly, but he attends recreational activities. He has one troublesome habit; he spits on the walls. However, the nurse felt that he accepted supervision well and that this habit could be controlled by the closer and more individualized supervision possible in a family environment. He has presented no other problem in care. The physician felt that he would require simply an accepting environment and moderately close supervision. A family member would not have to be with him constantly.
>
> His family consists of both parents, three sisters, and a brother--all in the home. He has had a number of leaves of absence and, according to the medical record, has adjusted well at home. Home conditions and available supervision were judged adequate and the family seemed accepting. The parents agreed to take G. on leave of absence in the spring and to keep him (on trial visit) if he adjusted. While there remains some element of question as to whether the parents will finally accept trial visit for G., the worker felt that they were sufficiently interested in G. that they would be willing to accept

> this responsibility. They explained their desire to wait until spring on the basis that they would then be able to take G. for drives in the family car and thus provide him with greater activity and recreation.

. . . .

G. is somewhat less regressed than most of the patients considered in connection with this study. He has more to offer the family who takes him, so that it would not be entirely a burdensome thing. In addition, his requirements for care and supervision are somewhat less strenuous. These factors should make it easier for a family to meet his needs. He is also believed to be entitled to a pension of one hundred and three dollars per month if placed in the community, an amount which should be sufficient to meet the cost of caring for him. It would seem (again) that an active exploration of relative resources might have made possible the placement of this man at an earlier date.

CASE NO. 4

> A. is a fifty-one year old, single veteran of World War I. He has been hospitalized for twenty-one years and he carries a diagnosis of dementia praecox, hebephrenic type. The physician has described him as a quiet and cooperative patient and as neat and tidy in his personal appearance. He was generally relevant, but was sometimes irrelevant in his replies during the most recent psychiatric examination. He talks to himself considerably and vaguely admits hearing voices, but he is not aggressive and causes no trouble on the ward. He does some ward work (polishing floors) and goes irregularly to hospital entertainments, but he tends to be asocial. His condition is reported to have remained relatively unchanged for some time.
>
> While A. has adjusted well to hospital routine, it was felt necessary that he have close or semi-continuous supervision in the community. During an earlier trial visit, he left his sister's home (in a neighboring state) without permission and came to Boston without means to care for himself. It was necessary to request (by correspondence) that a social worker from the nearest V.A. Regional Office contact the sister and furnish a report to the hospital. Because of her own ill health and A.'s need of close supervision, she

> felt unable to accept him. However, she approved of boarding home or nursing home care, prefering the latter. A nursing home (operated by a woman who has had training in psychiatric nursing) has since agreed to accept A. at forty dollars per week. Adequate funds are available, since A. has an estate of over $15,000. An available bed in the nursing home is being awaited.

. . . .

This case illustrates the contemplated use of one type of community resource available for quiet, elderly, or infirm patients who have sufficient funds available. A nursing home was chosen only because of the sister's preference and because of the lack of an established family care program at the hospital.

While there were some factors unfavorable to this man's placement--the requirement of close supervision, the fact that he still hallucinated and was somewhat irrelevant, his associality, his age and lengthy period of hospitalization, and the lack of relatives able to give adequate supervision--there were several favorable factors. He had adjusted well to hospital routine. He was fairly alert, fairly responsive to his environment, and generally relevant. He possessed financial resources adequate for the purpose of his care in the community. His relative was found to be interested in his placement. In view of these factors and the fact that his mental condition is reported to have remained relatively unchanged for some time, it would appear that an earlier effort to place this man might have spared him several years of hospitalization, made an additional hospital bed available, and saved the Veterans Administration much of the cost of his care.

CHAPTER V

PATIENTS WHO WERE NOT PLACED ON TRIAL VISIT AND FOR WHOM NO PLAN OF PLACEMENT HAS BEEN COMPLETED

A: Patients in Connection with Whom Social Service Activity was Continuing

Efforts were continuing in connection with the attempts to place eight of the remaining eighteen patients at the time the final data of this project were collected. In each of these cases there remained, therefore, a possibility that the patient would eventually be placed in the community as a result of social service activity undertaken in connection with this project. For this reason, it has been felt best to consider the cases of these eight patients separately from the cases of the remaining ten patients with whom the effort at pre-trial visit planning was considered by the social workers as concluded.

A variety of factors have served to prevent the placement of these patients within the time limit of the study. However, it appeared at the time these data were collected that at least one of these eight patients would be placed on trial visit. The case of this patient is presented below:

CASE NO. 5

H. is a thirty-nine year old veteran of World War II. He carries a diagnosis of dementia praecox, catatonic type; and he has been hospitalized slightly over three years. He has shown gradual improvement over the course of his hospitalization. The psychiatrist felt him to be quite alert and in excellent contact with his environment. Gross mental symptoms were considered to be largely in remission. In addition, he was considered to have been an excellent worker in one of the hospital kitchens. He has continued to evidence tendencies toward depression, and he has had his privilege to go

about the hospital grounds withdrawn on more than one occasion because of drinking. While he was not considered to be a chronic alcoholic, he has drunk excessively in the past. He tends to become easily upset over minor difficulties or criticism.

The physician recommended that simple, manual employment and suitable living quarters be obtained for H. prior to the granting of trial visit. He recommended that employment obtained be such that H. would be under a minimum of emotional or other stresses. A rooming house or the Y.M.C.A. would provide suitable living quarters, as H. was not considered to require direct supervision of his daily activities if placed in the community. However, it was considered that he would require close supportive supervision by the social service department. The physician felt that repeated placements on trial visit would probably be necessary before H. would be able to remain for a long period in the community.

Considerable delay was involved in securing the father's approval, as he lived outside of the area within which visits are made by hospital social workers, and he failed to answer correspondence. It eventually proved necessary to request the aid of a regional office social worker. However, when actually interviewed, the father proved accepting of the proposed plan and was willing to forward any needed funds to H.

At the time final data were collected, social service activity was continuing in the attempt to locate suitable employment and living quarters. Placement of H. in his own home was not considered because H. reacted strongly against this and because the father is elderly and in ill health. H. also reacted unfavorably to the suggestion of a farm placement.

. . . .

This case illustrates somewhat different obstacles to placement than the preceding cases. Here is a patient who has definite tendencies toward depression, who is easily upset by minor events, and who tends to drink when depressed. He is a man who probably should have warmth, interest, acceptance, and mild supervision from a family group, but who probably would be reluctant to accept this under any circumstances. In addition, his fairly long period of hospitalization has allowed him to become sufficiently dependent upon institutional routine so that it will probably

[illegible]

[illegible]

[illegible]

[illegible]

. . . .

[illegible]

be quite difficult for him to make an immediate independent adjustment even with close supervision from the social service department. His particular needs are such that it is difficult to meet them with existing community resources.

This case also illustrates something of the role of the social worker in pre-trial visit planning with such a patient and the type of plan which can sometimes be made; either institutional employment (with or without quarters) or carefully selected, simple, manual employment with a room in a Y.M.C.A. or private rooming house. Assistance to patients in obtaining such types of employment and living quarters is commonplace for the hospital social workers. The active social worker anticipates no unusual problem in helping H. to obtain these, now that the father's cooperation has been obtained.

An active social service approach at an earlier date would probably not have made possible an earlier placement, since H. was not ready for it. However, by such an approach a relationship with the social worker might have been established which would make possible greater support to this patient upon his leaving the hospital. There would seem indication that the major problem in connection with H. will not be the problem of helping him to find employment and living quarters but rather the problem of providing him with sufficient support to enable him to adjust when placed in the community. Trial visit planning may, thus, become an extended or often repeated process with this man before an eventual community adjustment is obtained.

Three patients with whom social service activity was continuing lacked known close relatives. While trial visit planning was somewhat deferred (so that its final result will have been realized at a date beyond the period covered by this report) by the fact that two of these patients did not want to leave the hospital until spring, the above lack appears to have been of greater significance from a total planning point of view. These three cases are, accordingly, considered as a group, and two cases are presented below as illustrative. The situation encountered in the attempt to plan for the third patient was quite similar to the case situation described immediately below, except that the third patient was able to perform only very light tasks because of somewhat greater physical infirmity, except that his period of hospitalization was considerably less, and except that he was a considerably more sociable patient. Efforts to locate boarding homes were either contemplated or were to be continued in these two cases; and in the second case illustrated, efforts were continuing to place the patient with friends.

CASE NO. 6

B. is a sixty-seven year old veteran of peacetime service who has been hospitalized for thirty-six years--over one-half of his present life. His diagnosis is dementia praecox, simple type. According to the physician's evaluation, he is considered to have adjusted quite well under hospital supervision, although his memory is "grossly defective" for recent events and he shows some other deterioration of his mental functions. He does not hallucinate and he generally gives relevant replies to questions. While he has been apathetic and asocial on the ward, he is considered fairly well able to relate himself to his environment (i.e., to be in "fairly good contact"). His mental condition has been considered relatively static for some years. He is somewhat infirm physically. The physician felt that if he were to be placed in the community he would require sufficiently close supervision to prevent him from wandering far by himself lest, due to his memory defect, he become lost or perhaps fall into other difficulties.

All reports from the medical rehabilitation department have been quite favorable. He has been working on the poultry farm for some time and there he is considered dependable and of much value. He has shown the ability to do a variety of simple light tasks without close supervision and he has shown sufficient initiative to always keep himself occupied. He was believed capable of doing this sort of work outside of the hospital, and the hospital industries supervisor felt that he could be a useful handyman about a farm.

When interviewed by the social worker, he seemed to lack a definite attitude toward leaving the hospital, and it appeared that he probably would be accepting of any type of placement offered him. He appeared apathetic, shy and withdrawn and was unable to give definite information concerning relatives.

Some effort has been made to locate a boarding home for B., and the worker planned to continue these efforts. Fortunately, he is believed to be eligible for compensation (pension) at seventy-two dollars per month if placed in the community. Unfortunately, the lack of more ample funds was considered by the social worker to have made the problem of locating a boarding home more difficult.

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Factors which have impeded the placement of B. appear to have been: (1) the lack of known close relatives; (2) the lack of a family care program with regular procedures for home-finding and funds available for supplementation of the patient's financial resources; (3) the limited financial resources of the patient; (4) his age, general physical debility, and mental deterioration which limits his usefulness to the performance of simple, light tasks; and (5) his memory defect which will require that he have fairly close supervision of the type described above.

Favorable factors appear to have been: (1) He has shown usefulness and adaptability on the poultry detail which has led his supervisors to believe that he could do similar light work outside of the hospital. (This fact may be particularly significant toward enabling his placement in a boarding home at a cost which could be met from his own funds.) (2)

He has made a generally good hospital adjustment and has been no problem in care or management. (3) He seems to show no mental symptoms of types which would be especially difficult to cope with in a home. He is considered harmless and apparently is not given to unpredictable behavior.

This patient's mental condition does not appear to have changed significantly for some time, while, on the other hand, his physical condition has deteriorated with increasing age. This, then, would appear to be indication that an earlier active social service follow-up with B. might well have enabled his placement in a boarding home at an earlier date. This would appear particularly true had a family care program (providing funds to cover at least partially the costs of care) been in operation.

CASE NO. 7

V. is a fifty-six year old veteran of World War I who has been hospitalized for fifteen years. His diagnosis is dementia praecox and chronic alcoholism. V.'s condition seems to have remained relatively unchanged over a considerable period of time. He is greatly bothered by a "death ray" and stuffs books and papers in front of his abdomen to stop this ray. He hears voices but does not react to them. He is well oriented and in good contact with his environment, and he reads considerably. On the ward, he is cooperative and causes no difficulties, but he is seclusive. He has many paranoid ideas, but apparently these ideas and his other peculiarities have not prevented his adjustment in the community for several short periods. The physician felt that he might adjust in the community at a minimum level with close supervision; i.e., general supervision of his daily activities.

V. has no interested relatives, but two families (both friends) have maintained an interest in him and have taken him out of the hospital numerous times on leaves of absence. One family took him on trial visit for a brief period during 1946, but they were unable to keep him long because of lack of room in the home. On this occasion, he wandered harmlessly about the streets until questioned by the police concerning the magazines under his belt. Afterward he stayed quietly in the back yard. He has caused no trouble in the home; and he has apparently not drank.

During the course of this project he was gotten out of the hospital on a leave of absence which was to have been changed to trial visit if he adjusted, but he came back voluntarily, saying that the rays bothered him and he did not want to stay out. Plans are being made for a trial visit placement with one of the two families in the spring, when he feels that the rays will bother him less.

V. would not be able to stay with one family permanently, since they do not have sufficient room. The other family have not felt able to provide supervision and care for V. over long periods because of restrictions which his presence has placed upon their activities. He has no known close relatives.

Although records were not definite, he is believed to have an estate of approximately $3400 and is believed to be receiving insurance proceeds of $30.40 per month. No pension has been awarded V.. Whether one could be obtained for him is unknown.

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Although immediate trial visit for V. was prevented by the fact that he wished to return to the hospital until spring, other factors seem to have been operative in the past in preventing lengthy periods outside the hospital for V. These factors continue to exist and must, therefore, be considered as unfavorable to placement at the present time. First, V. has no close relatives. Second, his only friends have felt unable to care for him beyond brief periods--and there is indication from the data available that their circumstances and their attitudes have not changed materially.

On the other hand, this case seems to illustrate that--in spite of gross mental disturbance, peculiar behavior, and paranoid ideas--V. has indicated the ability to make a minimal adjustment in the care of families who have been able to provide him with acceptance and close supervision. Moreover, he appears to have some funds available to pay for his care. (Meanwhile, there would seem to remain some important questions unanswered: Are his funds now adequate to provide for the cost of his care in the com-

munity? Could a pension be obtained for this patient? Would his friends be more willing to care for him if they were compensated?)

Since his mental condition appears to have remained relatively static for some time, it would seem that whatever possibility of trial visit now exists might have existed at an earlier date.

In one case, the only close relative was unable to provide supervision because of unemployment.

CASE NO. 8

R. is a fifty-six year old veteran of World War I who has been hospitalized for twenty-five years. His diagnosis is dementia praecox, simple type. He is another harmless, regressed schizophrenic patient who is reported to have changed little during the past several years. At the time of his latest mental examination, he gave relevant and coherent answers to questions and no hallucinations or delusions were elicited. About the ward, he is quiet and cooperative but childish in his reactions. However, he has presented no problem in care, and he helps with the ward work. He attends recreations, but he tends to stand quietly by himself on the ward when not working. The physician felt that moderately close supervision of R.'s daily activities would suffice; i.e., he would not have to be constantly observed and possibly could be permitted some freedom.

When interviewed by the social worker, he was found to be a shy, withdrawn old fellow who talked in a very low tone and seemed friendly but somewhat apathetic. He was willing to leave the hospital, but seemed to have little real grasp of what it would mean to be placed in the community.

His only close relative is a sister, who visits him frequently. She has taken him to her home on short leaves of absence and stated that he causes no difficulty. He likes to go down town with her and to attend movies with her. At home, he listens to the radio some and occasionally looks at pictures in magazines but, on the whole, is rather apathetic. The sister was unable to keep him, as she is living alone and is employed. However, she was willing for him to be placed in a boarding home.

R.'s pension status has been under review by the adjudications board and it has not been possible to determine with certainty the

> exact amount of monthly compensation to which he would be entitled if placed in the community. If the amount to which he is finally determined to be eligible should prove adequate (from information on hand it is believed it will prove so) it was planned to actively seek a boarding home for him.*

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The fact that R. has no close relatives who are able to supervice him has made impossible a placement with relatives and has required the consideration of alternative plans. Meanwhile, the uncertainty regarding his exact pension status has deferred, at least, an actual attempt to locate a boarding home for him. These have been the most clearly discernable obstacles to date. It is to be anticipated, though, that additional difficulties may be encountered in an attempt to locate a boarding home in view of the lack of an organized family care program. R.'s age, his very long period of hospitalization, his marked apathy and withdrawal have been other factors unfavorable to placement. His mental state, his age, and his severe hypertension would make it impossible for him to do much work in a boarding home placement, whereas the ability to help with the livestock, mow the yard, et cetera, would be an asset to placement.

Factors favorable to his eventual placement would seem to include the sister's willingness to consider boarding home care, the existence of sufficient funds, and the fact that R. has been a quiet and cooperative patient who is pleasant, if withdrawn, and no problem in care or management at the hospital. The fact that he has adjusted without difficulty in his sister's home is also a factor in his favor. Since the mental condition

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* It has been more recently learned by the writer that R. possesses an estate of approximately $6200 and that his pension would be at least $70.50 if he should be placed in the community.

of R. appears to have remained relatively static for several years, the existence of a family care program might have made possible placement in the community at an earlier date.

With two patients where social service activity was continuing, rejection or disinterest on the part of the relatives appears to have been the primary obstacle encountered. One of these patients was considered to be fairly sociable and able to perform simple tasks well with supervision--but the relatives appear to have gradually lost interest over the eleven year course of his hospitalization. Whereas the relatives once visited, there have been no visits within the past year and one-half. Moreover, the wife (and guardian) has failed to acknowledge three appointment letters. Efforts are continuing in the attempt to secure interviews with the relatives. Since this has not been accomplished, it is impossible to fully evaluate the possibility of placing this patient, but the possibilities of both a relative placement and a boarding home placement have remained under consideration. There remained question as to adequacy of funds available to provide for boarding home care, as it had not been determined whether his wife and children were receiving a portion of his compensation as dependents. However, there was believed to be the existence of an estate.

Boarding home care remained the only possibility under consideration in connection with the other patient, whose case is presented below:

CASE NO. 9

M. is a thirty-nine year old, single veteran of peacetime service who has been hospitalized ten years. His diagnosis is dementia praecox, hebephrenic type. He is described as pleasant, cooperative, simple, childish, and inadequate by the physician. Sometimes he has been very simple, mumbling to himself, "that's a telephone," or "that's an airplane." However, he has freedom of the hospital grounds and has gotten into no difficulties. Also, he is considered very dependable at running errands and at performing other simple tasks. He has a general reputation for agreeableness. He is fairly sociable on the ward, goes to all of the entertainments, and reads. He mumbles to himself considerably. He has a gluttonous appetite. If placed in the community, it was felt that he would require general supervision of his daily activities, and particularly supervision of his diet to prevent over-eating.

The social worker felt that M. would be happy anywhere. He impressed the worker as a "big, overgrown boy" who was very simple and agreeable, and relevant in his answers.

The only close relatives of M. are his parents. When interviewed concerning placement with them, they were felt to be very disinterested and rejecting of him. Both seemed quite defensive about their rejection, however, and expressed considerable hostility both toward the hospital and the worker. They blamed his (peacetime) military service for his illness and felt that the government should continue to care for him "for the rest of his natural life." The mother claimed inability to control his appetite while at home. She also felt that the presence of M. would interfere with her social life and her vacations. The mother was a decidedly dominating and aggressive person. The home was large and "very beautiful," and the family were believed to be in quite comfortable economic circumstances.

In view of the parents' expressed attitudes, the worker did not inquire specifically concerning the parents' attitudes toward family care. However, it was later noted that the mother had spoken favorably of family care at the time M. had been transferred to Bedford from another hospital, not many months previously. She had then expressed willingness to pay the entire amount of his pension--$103 per month--for such care. In view of this earlier favorable expression, the social worker planned upon contacting the parents again in order to determine their present attitude toward boarding home care. If the parents were to approve of this plan, it was proposed to seek a boarding home for M.

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Here there is indication that strong emotional rejection of M. has been a primary factor in the parents' refusal to accept him on trial visit. It seemed emotionally necessary for these people to avoid any conscious feeling of responsibility either for their son's illness or his care. In addition, there is some indication that the parents also wished to avoid the possibility of social embarrassment. This seems particularly indicated by the mother's expressed feeling that his presence would interfere with her social life. Moreover, the possibility of social embarrassment would seem real in view of M.'s extremely simple and childish behavior and the parents' better-than-average economic and social status.

That M. has also been an unwelcome problem in care to this aggressive and socially minded mother is perhaps indicated by her insistence that she cannot control his appetite. Therefore, while strong emotional rejection on the part of the parents would seem to have been the primary obstacle to placement of M. with his relatives, his seriously regressed condition and his requirements for care and supervision have been factors which have also had a negative effect. These factors provide limitations to be considered in connection with any plan for placement.

On the other hand, his general pleasantness and willingness are favorable factors for placement, if permission to utilize boarding home care can be obtained from the parents. The fact that he functions at the level of a seven or eight year old child would not necessarily prove a serious obstacle to a boarding home placement, as his childish dependency might prove more gratifying to certain types of individuals than more adult behavior would be. In addition, there is evidence that he could probably be useful at

simple tasks about a home or farm if given sufficient supervision.

In the final analysis, the possibility of utilizing boarding home care for M. would seem to depend largely upon the parents' present attitude toward this type of placement for him and upon whether a suitable boarding home could be located. It would seem that the existence of a family care program might have made possible the placement of M. in the community at a somewhat earlier date, in view of the mother's earlier expression of a favorable attitude toward such a plan (if she was sincere).

In one case, it did not prove possible to locate existing relatives within the time limit of this project, but efforts were continuing to locate these relatives through the assistance of a regional office social worker. There appeared to be relatively little possibility of placing this patient, but no final determination could be made on the basis of existing data.

CASE NO. 10

J. is a forty-eight year old veteran of World War I who has been hospitalized continuously for eleven years. His diagnosis is dementia praecox, catatonic type. His condition seems to have changed little during the past several years. He is considered to be in good reality contact and does not show indication of hallucinations or delusions. He is always neat and tidy. He has been relevant and coherent in his replies when examined. He is quiet and cooperative on the ward, but he is asocial, and he does no work. He attends hospital movies and reads some. He drank excessively before his admission, and it has not been possible to allow him unsupervised freedom about the hospital grounds because he has attempted to bring in liquor. It was recommended that he be provided with good supervision if placed in the community, but he would not need to be constantly watched.

J. was on trial visit for five months in 1942 and for six months in 1943, both times in the home of his parents and sister. On each occasion he adjusted well for a time but began to drink excessively

toward the end of the period. He was employed in a shipyard for most of the latter trial visit period. The parents again wanted to take J. in 1945, but trial visit was disapproved because both parents were in their eighties and it was felt by the medical staff that they were unable to provide adequate supervision.

When interviewed by the social worker, J. was found to be a neat, soft-spoken, mild-mannered individual. He was friendly and talked fairly freely, but without emotional response. He was anxious to leave the hospital and desired to go with his parents.

Investigation has shown that the mother is now deceased. The father is reportedly living with his brother. The whereabouts of the patient's sister are unknown. An attempt is being made to locate the father through one of the Veterans Administration regional offices. Proposed activity is to continue efforts to contact the family and determine if any one of them is able to assume responsibility for J. and to give him adequate supervision. J. has no pension, no other income, and no estate.

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While J.'s family have not yet been contacted, it seems doubtful from what is known that any member of the family will be able to accept responsibility for his care and give him adequate supervision. The father has not been able to give adequate supervision in the past, and is not now, apparently, maintaining a home of his own. The sister was single in 1945 and, if still single, would probably not be able to give adequate supervision to control this man's drinking. No other immediate relatives are known to exist.

Boarding home care might be a possibility for J., were sufficient funds available. However, even if a pension could now be obtained for him, it probably would not be in excess of sixty dollars per month. This is the maximum award allowable to a veteran who is not considered to have a service-connected disability and who has neither reached the age of sixty-five years nor been in continuous receipt of the sixty dollar amount for

ten years.[1]

The fact that he was able to remain on trial visit for five months and for six months in spite of inadequate supervision would seem to indicate that this patient's condition is not hopeless and that he might be able to make a minimal adjustment in the community, could adequate supervision be provided for him. Had a family care program providing funds for boarding home care been in operation, it might have been possible (even at an earlier date) to have overcome the obstacle to placement provided by inadequate family supervision. This case illustrates the importance of a provision for payment of maintenance from government funds in instances where the patient's own financial resources are inadequate.

The fact that J. was able to secure and maintain employment for several months during 1943 seems to illustrate that surprising adjustments can sometimes be made by a patient who has remained quite ill.

B: Patients with Whom Pre-trial Visit Planning Has Been Carried to Conclusion without Placement

In connection with ten cases, the effort at pre-trial visit planning must be considered as unsuccessful. In these instances the patients had not been placed on trial visit, no plan for their placement had been created, and the effort at pre-trial visit planning had been discontinued by the worker.

In three instances, planning was discontinued because of the patient's expressed unwillingness to leave the hospital. One of these patients was a

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[1] Source: Information obtained from Mr. A. C. McCarthy, Veterans Contact Representative at the Bedford Veterans Hospital.

twenty-eight year old veteran of World War II who is quite ill. He was included in this study primarily because of the known strong interest of the relatives in him. However, he was found to be very opposed to going to the home of his parents, and boarding home care was not considered for him. He has been quiet and cooperative about the hospital, but he has remained confused, hallucinated, and seclusive.

Another patient was a sixty-one year old veteran of World War I. He was diagnosed psychoneurosis, reactive depression. He has been hospitalized for four years. He has shown gradual and steady improvement in his condition and recently has made a very good hospital adjustment. The physician felt that he would not require close supervision, if placed in the community. Although it was recorded that he had quite recently "reacted favorably" to the suggestion of leaving the hospital, he was found to be opposed to leaving the hospital when interviewed by the social worker. In view of this, the physician advised that trial visit planning be discontinued.

The case of the remaining patient in this group is presented below for the purpose of fuller illustration:

CASE NO. 11

G. is a thirty-four year old, single veteran of World War II who carries a diagnosis of dementia praecox, paranoid type. He has had but two years of hospitalization. While G. was very ill when admitted, he has improved considerably during the past year. He is considered to be in good contact with his environment and he is not hallucinated. He has full privileges to come and go unattended about the hospital grounds. For several months he has been working in the print shop, operating hand and automatic presses, setting type, and performing other skilled operations. He is considered to be very cooperative there. However, he continues to be extremely fearful of people and tends for this reason to shun dances, movies, and other recreational events. He still has traces of earlier ideas that he makes other

people uncomfortable by looking at them; but he is considered now to have fair insight concerning his illness. He has gotten into no difficulties about the hospital grounds or with other patients; and he has been no problem in care. The physician felt that he would require only moderately close supervision, such as a family would be able to provide where someone was usually, but not necessarily always, at home. He was not considered well enough for regular employment.

When interviewed by the social worker, G. became very upset at the prospect of leaving the hospital. He insisted that he felt too sick and too weak and that he could never go outside among "a lot of people." In view of G.'s strong feelings, no further efforts were were made toward trial visit planning.

Little is known concerning the family. However, he has several relatives who have visited and otherwise maintained an interest in him. He is believed to be eligible for the maximum monthly disability compensation of $138 if he were to be placed in the community.

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Here, the primary obstacle encountered was G.'s fear of leaving the hospital. For this reason no further effort at trial visit planning was attempted. If G. could be aided--through an active social service approach or otherwise--to overcome his fear of leaving the hospital, it would seem that placement might be possible, since the family has given some indication of interest in him, since G.'s pension would provide ample funds for boarding home care, and since G.'s adjustment has been quite good within the hospital.

Similar conclusions might be drawn from the case of the sixty-one year old World War I veteran mentioned above, the writer feels.

In the following <u>five</u> cases, relatives have proven either unable or unwilling to accept responsibility for the patient and to give him adequate supervision. While there have been other unfavorable conditions present in each case situation, the above appears to have been a primary obstacle to

placement in each instance.

In one of these cases, the relatives were found to be openly disinterested and rejecting, and were opposed to any plan except continued hospitalization:

CASE NO. 12

B. is a forty-eight year old veteran of World War I who has been hospitalized continuously for eighteen years (in addition to five years of earlier hospitalization). His diagnosis is dementia praecox, hebephrenic type. He, again, is a chronic regressed hebephrenic patient who has shown little change in his condition in recent years. According to the physician, he is able to answer questions fairly coherently, and he denies hallucinations, but he feels his body is weak and soft. He takes care of the day room on the ward and is considered to have adjusted well to ward routine. He has been a quiet, cooperative, and apathetic patient. The referring physician felt that he might be able to adjust in the community at a minimum level in a family environment, provided someone would be present to provide general supervision of his daily activities.

When interviewed by the social worker, he seemed quite apathetic. He volunteered no conversation but gave relevant, short answers to questions. He seemed indifferent toward leaving the hospital, but expressed willingness.

The known relatives consist of two brothers living in a neighboring state. They have shown little interest in B. At the request of the hospital social worker, one brother (who is the patient's guardian) was contacted by a social worker from the nearest regional office. This social worker described him as an uncooperative individual who felt his brother to be the government's liability and who was quite resistive to any plan except continued hospitalization. He insisted that neither he nor his brother could take B. because both were employed, although both are married.

B. has an estate of approximately $14,000 and, in addition, would be eligible for compensation for a one hundred per cent service connected disability--$138 per month--if placed in the community. In view of the guardian brother's attitude, no effort has been made to contact the other brother, and no further social service activity was planned.

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The primary factor obstructing placement in this case has been the

hostile, rejecting, and disinterested attitude on the part of the guardian brother. Parallel to this is evidence of disinterest or rejection on the part of the other brother. If any plan were to be made for the placement of B. in the community, it would probably be necessary to enlist the cooperation of the Chief Attorney and seek to have the brother removed from the guardianship. (A precedent for such action has been established in other instances where the guardian has been disinterested or has blocked planning for a patient.)

We might also consider as negative factors B.'s apathy, limited responsiveness to his environment, and requirements in the way of care and close supervision. His very long period of hospitalization might make it difficult for him to adjust to a non-institutional routine. On the other hand, he is a harmless, inadequate individual who has adjusted well to hospital routine and has presented no particular problems of care or supervision. There is evidence that he would be able to perform some light tasks about a home if his interest could be sufficiently stimulated. In addition, ample funds are existing to provide for his needs in the community.

In three of the five cases illustrating unfavorable relative situations as a primary obstacle to placement, there have existed multiple negative elements in the relative situation--but, in each instance, disinterest and/or rejection appears to have been a basic element. These three cases are illustrated below:

CASE NO. 13

B. is a fifty-seven year old veteran of World War I who has had twenty-two years of continuous hospitalization. He carries a diagnosis of dementia praecox, hebephrenic type. His mental condition appears to have changed little in the past several years, except that he has become gradually more withdrawn and apathetic. Medical reports describe him as able to answer questions coherently and as having maintained "fair mental grasp and capacity." His comprehension and attention were good. He has shown no evidence of either hallucinations or delusions, and he was approximately oriented. On the ward he is neat, tidy, and cooperative and has caused no trouble. He is, however, seclusive and practically mute on the ward and he takes little interest in his environment or in recreation. The physician felt that he might be able to adjust at a minimum level in a family environment, provided close supervision of his daily activities could be given.

He worked at mopping the hospital tunnels for years. The hospital industries supervisor described him as always quiet, cooperative, and very neat. Although he seemed somewhat confused and showed no initiative, he always followed instructions willingly and was able to do simple tasks well. She felt that he would be "absolutely no trouble" in a home. However, he now has no detail; and he has been idle about the ward since 1945.

The social worker described him as a meek, agreeable, and passively cooperative individual who appeared to be somewhat confused but not irrelevant. He answered questions willingly but made no positive suggestions. However, he was very anxious to leave the hospital. He has not been out of the hospital for a number of years, except that he once eloped and became lost in an attempt to locate his relatives.

His relatives have shown little interest in him. There have been no visits for three years, and few or no packages have been sent him. When contacted, they seem disinterested and rejecting. They also were unable to provide adequate supervision, as only his seventy-one year old sister is home during the day. They lacked room so long as they kept a young couple who were boarding in the home. Since it is his sister's daughter and her husband who are maintaining the home, it is perhaps not to be expected that they would take a strong interest in him. However, they were agreeable to his being placed in the community provided another plan could be worked out. The guardian was also found to be agreeable to such a plan.

He is rated eligible for compensation for a one hundred per cent service-connected disability, but is receiving no compensation at present because of his hospitalization and the existence of a $2000 estate. He would be expected to receive $138 per month if placed in the community.

> In view of B.'s regressed and partially confused mental condition, his age, his long period of hospitalization, and the lack of any known boarding home within which he might be placed, no further effort toward placing him was contemplated.

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Multiple factors appear to have limited the possibility of placing this patient in the community: (1) The relatives actually maintaining the home--who would have been primarily responsible for his care--expressed frank disinterest or rejection. (2) These relatives were not immediate relatives. He, therefore, lacked close relatives except for one aged sister who lacked the means and ability to provide for his care or supervision. (3) The only capable relatives were employed; and there was insufficient room for his care in the home without the displacement of remunerative tenants. (4) The patient himself was considerably regressed and withdrawn mentally, as well as partially confused. For these reasons, he would provide a problem of care and supervision, although he would probably not be purposefully troublesome or annoying, if the evaluations of the ward personnel and of the hospital industries supervisor can be considered sufficiently indicative. (5) The amount of work which he would be able to do in a boarding home would be limited. (6) His age and his long period of hospitalization contributed additional unfavorable factors.

On the positive side, he has ample funds available to meet his needs in the community and both the family and guardian are willing for him to be placed in the community. While he is considerably regressed, he is neither hallucinated, disoriented, nor irrelevant. He has never been a troublesome patient at the hospital; and he is considered able to perform simple tasks when adequate directions and supervision are given.

On the whole, this patient would appear to have been less seriously regressed than some patients who were described by Hester Crutcher (see Chapter II) and others as having been successfully placed in family care, and it is, therefore, the feeling of the writer that the provision of the type of care and supervision recommended by the physician might have been possible had an established program of family care been in operation. Since he appears to have gradually regressed over his long period of hospitalization, it would appear that the existence of a family care program might have made placement in the community somewhat more readily possible at an earlier date.

CASE NO. 14

G. is a sixty-one year old married veteran of World War I who has been hospitalized for twenty-six years. His diagnosis is dementia praecox, paranoid type. He is considered to be a simple and childish patient who is fairly talkative, but who "rambles along in a rather irrelevant and incoherent manner." He is considered to be in good contact with his environment--though he shows a limited interest in it. However, he has many strange, bizarre, deluded ideas--all rather incoherent--and he claims to be bothered by electricity. He is fairly sociable on the ward and has never been assaultive or troublesome. He attends recreations, and he has grounds privileges which he has not violated. He is a cooperative ward worker, and he is neat and tidy. He has some physical infirmity. Close or semi-continuous supervision of his daily activities was recommended--as with the majority of these patients--if he were to be placed in the community. However, it was felt by the physician that he might be able to adjust at a minimum level in a family environment of an adequate nature.

His mental condition is reported to have remained relatively unchanged for fourteen years. The social worker found him quiet, polite, soft-spoken, neatly dressed, and willing to leave the hospital--but deluded.

The family consists of the mother, the wife, and three others living in a small second floor apartment. For this reason alone, they could not take G. In addition, the mother is seventy-two years of age, nervous, and did not feel that she could "make the adjustment." There seemed no longer to be a close feeling toward G. on the part of

other members of the family. They considered him too ill and too long hospitalized to consider any plan but continued hospitalization --although G.'s funds are adequate to meet his needs in the community. No further social service activity was planned.

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Factors impeding placement in this case would seem to have been: (1) The relatives (with a possible exception in the mother) appeared to have lost any close feeling they may once have had for the patient during his long period of hospitalization. (2) The mother was aged and nervous and felt unable to adjust to the patient's presence. (3) There was no room for the patient. (4) The family was unwilling to approve of any other from of placement for him. The family related this attitude to his age, his long period of hospitalization, and his continued mental symptoms. These factors, his physical infirmity, and his requirements in relation to care and supervision would undoubtedly have made placement difficult had it been possible to consider other plans.

On the positive side might be considered such factors as his pleasantness, his harmlessness,.his neatness, and the fact that he has not been troublesome or a particular problem in care. Also, there were ample financial resources available to provide for care in the community. It might be noted that this patient's mental condition is considered to have remained relatively unchanged for fourteen years. In view of the nature of the family's objections to any alternative plan for placing G. in the community, the purely hypothetical question might be raised as to whether the family could have been persuaded to accept a boarding home placement for G. some years ago, had a family care program been in operation and had the patient been considered for such care.

CASE NO. 15

B. is a sixty-three year old veteran of World War I who has been hospitalized for seven years. His diagnosis is psychosis with cerebral arteriosclerosis. He also suffers general arteriosclerosis. B.'s memory for recent events is markedly defective. He cannot remember having received a package of cigarettes more than an hour or so. He has a "slight alcoholic history," and his privileges of going about the hospital grounds unattended have been revoked because he bought liquor (in town) and became intoxicated "infrequently." He is simple and childish. Otherwise, he is neat in dress and habits, cooperative, quiet, well oriented, and no management problem. He takes part in ward activities and spends other time reading. He is reported to have adjusted well on some leaves of absence several years ago to the home of his brother. On these occasions he did not (or was not permitted to) drink excessively. It is to be noted that there are notations in the record as early as 1941 that he could "probably" get along under his brother's supervision or "possibly" under domiciliary care. The referring physician felt that he would require sufficiently close supervision in the community to prevent him from wandering away or becoming intoxicated. With such supervision, he felt that B. might be able to adjust at a minimum level in a family environment.

When interviewed by the social worker, he expressed a desire to leave the hospital, but he did not wish to live with his family. (It is noted from his record that he has made repeated requests for discharge, but that the relatives have shown no interest in taking him.) He showed little insight, feeling that he could take care of himself. However, he was pleasant.

It was necessary to request that the relatives be contacted by a worker from the regional office. They have visited infrequently. A sister indicated a slight interest in B., but she was living in a hotel. The only brother appeared to be uninterested in B. Other sisters were not contacted, as the one sister stated they would not be able to take B. because of their own "family" and "financial" situations. It is believed that he would be entitled to monthly compensation of $103.50 if placed in the community. However, boarding home placement was not considered practical for him because of his alcoholic history. His age, infirmity, and lack of insight were other factors which entered into the worker's decision.

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Negative factors in this case would seem to have been: (1) Only one member of the family has shown any marked interest in this patient during the course of his hospitalization; but he (the brother) now appears to lack

interest. (2) The progressive nature of the patient's illness and his long period of hospitalization may have been factors related to the fact that the relatives appear to have formulated plans for their own lives without thought of him. These factors may also be related to their present disinterest, since the brother did take him out a few times several years ago. (3) "Family" or "financial" problems are implied as reasons why others of the relatives were unable to take B. (4) Boarding home placement was not considered practical for B. for the reasons indicated in the case summary.

This case again illustrates many of the difficulties that were encountered in the attempt to place these patients in the community. Whether this man could have been successfully placed in family care at an earlier date--when both his physical and mental condition probably were better than now--remains, of course, unanswerable.

In the remaining one of these five cases which illustrate relative situations unfavorable to placement, the relatives were found to be interested in the patient's welfare but to be unable to provide him with adequate supervision because of employment:

CASE NO. 16

B. is a fifty-seven year old veteran of World War I. His diagnosis is dementia praecox, paranoid type; and he has been hospitalized for thirteen years. B., again, is a chronic, partially regressed patient whose condition is considered to have remained relatively static for some time. He is described by the physician and by others who have had responsibility for his care as a pleasant individual, but he becomes evasive when questioned. He is considered to be in fairly good contact with reality; however, he does hallucinate some. He is generally quiet and cooperative on the ward, and he is never troublesome; but occasionally he becomes somewhat loud as he talks with his

voices. He is not considered impulsive or aggressive. The physician felt that B. might be able to adjust at a minimum level in a family environment and recommended close supervision similar to that prescribed for the majority of these partially regressed, custodial care patients.

B. has been on several work details about the hospital and is considered to have done well on all. The hospital industries supervisor considered him able to take care of chickens or pigs, to paint, to take care of a lawn, and to perform similar tasks in a home under moderately close supervision. She described him to be a "very handy man" and felt that he would be particularly useful on a farm. However, he has shown some peculiarities and tolerance of these would be required. He has shown some tendency to "take charge" when working in a group and occasionally has refused to perform a task or has quit early--giggling childishly (never being disagreeable) as he has done so.

When questioned by the physician, he was evasive but quiet. He would not state whether he would like to go with his relatives. However, when interviewed by the social worker concerning his relatives he became excited and somewhat loud, repeating "that's the whole trouble," and denying that they visited or had any interest in him. The worker felt he seemed quite confused and preoccupied.

B.'s immediate family consists of four children living together; also a brother and a sister who have been disinterested and whose whereabouts are unknown. When contacted by the social worker, the children seemed interested in B. but stated that they could not take him as all had to work in order to meet living expenses. In addition, all had ambivalent feelings concerning his mental condition and the youngest daughter (age twenty-one) expressed fear of him. They felt that he usually did not recognize them when they visited the hospital. He is believed to be eligible for a monthly disability compensation of seventy-two dollars if placed in the community.

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The primary obstacle encountered in the attempt to place this patient would appear to have been the fact that the available relatives were employed or planning to be employed and felt unable to provide supervision. In addition, they had ambivalent feelings concerning his illness and the fact that he frequently did not appear to recognize them; one openly expressing fear of him. The apparently negative attitude of the patient

toward his family also presented a situation somewhat unfavorable to a placement with relatives. Moreover, his illness was such that he would require considerable tolerance or acceptance, as well as close supervision, if he were to be placed in the community.

Some favorable or positive factors were, however, encountered. This patient was considered to have been a generally quiet and cooperative patient who has not been aggressive and who has not been a problem in care or management. Moreover, he was felt, on the basis of his hospital work adjustment, to be capable of performing numerous useful tasks about a farm. His children, at least, were interested in his welfare. Some financial resources (possibly sufficient for boarding home care, in view of his capacity to do some useful work) were available. Since the primary obstacle to placement of this patient was the inability of the relatives to provide supervision, it would appear that the existence of a family care program might have made possible the placement of this man. Since his mental condition appears to have remained relatively unchanged for some time, the existence of such a program might have made possible his placement at an earlier date.

The unrecovered mental condition of each of the patients studied was a factor tending to limit the possibilities for placement. However, there were <u>two</u> cases in which no attempt was made to place the patient in the community because it did not seem possible to provide any situation within which the patient might be expected to adjust--even at a minimum acceptable level. Both of these men were alcoholic; and both had drank excessively

during earlier brief periods with relatives. Both had been resistant to supervision by relatives; and both indicated unwillingness to accept close supervision when interviewed by the social worker. The wife (the only close relative) of one of these patients was contacted and found to be both unable and unwilling to assume responsibility for his care. No effort was made to contact the relative in the other instance. It is felt that little is to be gained by discussing these cases in greater detail.

CHAPTER VI

SUMMARY

Of the approximately one hundred and sixty-four patients in the two wards considered in connection with this project, one hundred and twelve were found to have had two years or more of continuous hospitalization. One hundred and two met all of the criteria utilized in the selection of the larger group. In the final analysis, twenty-two of the one hundred and two were felt to be suitable for pre-trial visit planning.

Case analysis has indicated that the majority of these twenty-two patients were partially regressed patients whose mental condition has become relatively static. Such patients might well be classified as harmless dependents, if the classification utilized at the Chicago State Hospital were to be adopted. The patients so classified at the Chicago State Hospital were "senile or deteriorated patients who were harmless and required purely custodial care."[1]

At least nineteen of the twenty-two patients were considered capable of adjusting at but a minimum (or near minimum) level of adequacy in a sheltered or accepting environment with adequate supervision. Employment was recommended for only two. Sixteen of the twenty-two were considered to require close supervision of their daily activities. The remainder were considered to require somewhat less supervision. In all but one instance, however, they were considered to require some direct supervision of their daily activities.

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[1] *Cf.* Worthington, *op. cit.*, p. 287.

One patient out of the twenty-two was placed on trial visit. (One other patient was placed on a leave of absence which could have eventuated in trial visit, but he returned to the hospital of his own desire because electric rays bothered him.) Plans had been made which it was believed would result in trial visit within a short time for three additional patients.

Effort toward eventual placement on trial visit were continuing with eight patients--and in each instance some possibility of placement was considered to remain. In connection with five*of the above patients, boarding home care was being considered, but family attitudes toward this type of care were unknown in two instances. No further effort was contemplated in connection with the remaining ten patients, and no satisfactory plan of placement had been created.

The patient placed on trial visit was placed with relatives. Of the three patients in the second group, plans had been made to place two of them with relatives and the third in a nursing home.

At this point, it might be well to indicate inferences which can be drawn upon further consideration of those four patients for whom a plan for placement had been created or (in one case) effected. The patient placed on trial visit (see Case No. I) does not appear to have been in better mental condition than the majority of these patients; and he was from among

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*There were six, if the patient for whom a placement with friends was being sought is included.

the group who were considered to require close supervision of his daily activity. At the time of his most recent mental examination, he admitted hallucinations, he was disoriented for time, and he was considered to be childish and apathetic. He has been asocial and practically mute on the ward. He has been disinterested in a work detail. And he has required patient handling and close supervision.

Among the remaining three patients, we find the following: Patient number one (Case No. 2) was considered to be listless, apathetic, and emotionally unresponsive. He has been disinterested in both work and recreation. He has spent most of his time sitting idly on the ward, mumbling to himself, openly hallucinating. He also was considered to require close supervision.

Patient number two (Case No. 3) appears to have been in somewhat better mental condition than the majority of these patients. He was not considered to be hallucinated or deluded. He was well oriented and able to respond to questions "quite normally." He has been little problem in care or supervision. On the other hand, he has felt physically sick and weak, he has done no work, and has been hospitalized continuously for nineteen years. Moderately close supervision was felt to be sufficient.

The remaining patient (Case No. 4) was considered to be hallucinated and was sometimes irrelevant in his replies to questions. He has been seclusive on the ward and has indicated only a mild interest in his environment. He has been hospitalized for twenty-one years; and he was considered to require close supervision.

Thus three of these four patients, in so far as their mental condition

was concerned, presented problems in regard to placement no less severe than the majority of the patients considered for pre-trial visit planning. The good fortune of three of these patients seems to have been largely due to the existence of fairly adequate home situations and to strong or fairly strong relative interest in their welfare. The contemplated placement of the fourth patient in a nursing home has been made possible largely by the interest and cooperation of the patient's sister and by the existence of adequate funds to provide for such care.

A considerable variety of factors appear to have combined to impede or prevent placement of the remaining patients. Three of the ten patients in connection with whom pre-trial visit planning had been discontinued did not want to leave the hospital, and planning had been discontinued for that reason. Planning was discontinued with two patients primarily because it was felt that they would be very difficult to supervise in the community. Both were alcoholic; both displayed unfavorable attitudes toward accepting supervision; and both had drunk excessively in the community on previous occasions, in spite of family supervision. The remaining five patients could not be placed with relatives; and boarding home placement was either not considered, or was concluded by the social worker to be impractical, or was disapproved of by the relatives.

In one instance, here, the relatives were openly rejecting or disinterested and opposed to any plan except continued hospitalization. In three instances, there were multiple obstacles to placement present in the relative situations, but disinterest and/or rejection appeared to have

been a basic obstacle. In <u>one</u> instance, the relatives were interested in the patient but were unable to provide adequate supervision because of employment or contemplated employment.

A variety of situations were represented by those <u>eight</u> cases in connection with which social service activity was continuing. In <u>one</u> case, delay was involved in contacting the father (guardian) but the patient could be placed on trial visit as soon as a job and a room could be located for him. In <u>three</u> cases, the lack of close relatives was considered the fundamental obstacle to placement, although in two cases the patient had been unwilling to leave the hospital "until spring"--which served further to prevent the placement of these patients within the time limit of this project. A boarding home placement was being sought for two of these patients, and a placement with friends for the third.

Continuing, in <u>two</u> instances, rejection or disinterest on the part of the relatives appeared to have been the primary obstacle encountered. In one instance, both boarding home placement and a relative placement remained as possibilities; in the other instance, boarding home care alone remained under favorable consideration. In <u>one</u> remaining instance, the only close relative was employed and was unable to provide adequate supervision. A boarding home was being sought. In the <u>one</u> final instance, it proved impossible to locate existing relatives within the time limit of this project, but it was felt that the relatives probably would not be able to provide adequate supervision if located. This patient lacked funds for boarding home care and also had a "somewhat alcoholic" background, leaving a relative placement as the only possibility continuing under favorable

consideration.

Summarizing all of the cases in which it appeared that unfavorable circumstances in connection with relatives presented a primary obstacle to placement, we find the following: <u>Three</u> patients lacked known close relatives. In the cases of <u>six</u> patients, the relatives were rejecting and/or disinterested in the patient's welfare. However, in three of these cases there were known to be other important barriers to a relative placement, such as lack of room, inability to provide adequate supervision, and, in one instance, living conditions which were considered unsuitable for the patient's placement. In <u>two</u> cases, the relatives were interested in the patient but were employed or expecting to be employed, and were for this reason unable to provide adequate supervision. In <u>one</u> instance, the social worker had been unable to locate relatives but efforts were continuing. (A further obstacle to placement was provided in <u>three</u> instances by relatives' refusal to accept any plan except continued hospitalization.)

Totaling these cases, we find that a lack of relatives willing and able to accept responsibility for the patient's care proved a primary obstacle to placement in <u>eleven</u> instances. Thus--while the unrecovered mental condition of these patients provided a universal obstacle to their placement, in some cases directly and in other cases indirectly--unfavorable relative situations have provided by far the most significant environmental obstacle encountered. This conclusion is further strengthened when we consider that various unfavorable factors in the relative situation provided secondary obstacles in connection with the placement of some of the other patients.

It must be kept in mind, however, that the above analysis represents considerable summarization of the situations encountered in the attempt to place each of these eighteen patients. The case illustrations presented indicate clearly that multiple factors unfavorable to placement existed in each case situation. Age, physical infirmity, and long periods of hospitalization were unfavorable factors encountered in several instances; and, as indicated above, the unrecovered mental condition of these patients must be considered as a universal obstacle to placement.

Further analysis of the case data indicates, on the other hand, that there were factors favorable to placement present in the majority of instances. Most of these patients were harmless, withdrawn individuals who have presented few difficulties in connection with their care and supervision within the hospital. Their principal requirements were for (1) general supervision of their daily activities, (2) tolerance of their peculiarities, and (3) acceptance at the level at which they could adjust. In addition, a few patients were reported to have been very useful workers about the hospital. These and several others were considered capable of performing useful tasks about a home or a farm.

While the financial resources of some appeared inadequate to meet the costs of boarding home care, the resources of others--according to hospital records or information obtained from the social worker--appeared adequate to provide for any type of care. One patient possessed an estate of approximately $14,000. Another possessed an estate of approximately $15,000. Both were entitled to disability compensation. A third possessed an estate

of approximately $6200 and, in addition, was entitled to a disability compensation (pension). Three other patients possessed estates, the amounts of which were unknown, but each appeared to be eligible for disability compensation of over $100 per month if placed in the community. Nine other patients appeared to be eligible for compensation of over $100 a month if placed in the community, and six of these appeared to be eligible for $138 per month. While there exists some uncertainty regarding the exact amounts available, it would appear, nevertheless, that at least one half of this group of patients possessed financial resources adequate to meet the costs of boarding home or other care in the community. In fact, when it is considered that many patients have been placed in Massachusetts at the rate of ten dollars per week allowed by the Commonwealth for boarding care costs, most of these amounts should be quite adequate.

CHAPTER VII

CONCLUSIONS AND RECOMMENDATIONS

The value of such a study as this lies largely in the extent to which its data can be generalized and utilized as a basis for planning and for action. Therefore, the following generalizations are suggested by way of overall conclusions:

(1) A limited number of chronic mental patients in the Bedford Veterans Hospital could probably be placed on trial visit with relatives through an active social service approach.

(2) The number of such patients who could be placed with relatives would be limited, however, by many obstacles such as disinterest or rejection on the part of relatives, inability of relatives to provide adequate supervision, inadequate living arrangements, and reluctance on the part of relatives to accept burdensome problems of care and supervision.

(3) The regressed mental condition of many chronic mental patients and their requirements by way of close supervision and of care would limit the possibilities of placement largely to placement within a family environment and would tend to make placement difficult. In some instances, other factors--such as age, infirmity, long periods of hospitalization, alcoholic backgrounds, and unfavorable attitudes twoard leaving the hospital or toward accepting family supervision--would tend to make placement difficult.

(4) An extensive survey of the literature in connection with family care (see bibliography and the discussion of family care in Chapter II,

section C) has led the writer to conclude that the general type of patient considered in connection with this project was not dissimilar to a type of chronic, partially regressed patient reported to have been frequently placed in family care by other mental hospitals. Harmless chronic regressed patients--physically infirm patients--mute patients--grossly confused and hallucinated or deluded patients--alcoholics--general paretics--mental defectives--senile psychotics--younger patients in the process of recovery--patients who have had shock treatment--patients who have had unsuitable or inadequate home environments to return to--and patients who have been felt able to adjust only in a sheltered environment--are among types of patients which have been described as having been successfully placed in family care.[1]

(5) There would seem to be indication that the greatest possibility for the placement of chronic mental patients in the community by the Bedford Veterans Hospital would lie in the utilization of boarding home or family care. This conclusion is supported by conclusions two and four; and it appears more than amply supported by the results and conclusions of other studies and other attempts to place chronic mental patients in the community. It is further supported by the fact--probably in contrast to situations found in state hospitals, where the greatest development of family care has reportedly taken place--that many chronic mental patients in the Bedford Veterans Hospital would have sufficient financial resources

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[1] Cf. particularly, Hester B. Crutcher, Foster Home Care for Mental Patients, chapters 1-4.

of their own, in the form of pensions or estates, to finance this type of care in the community. At least one-half of the group studied appeared to have sufficient financial resources.

(6) The development of a family care program would appear to be in accord with current Veterans Administration policies, as clarified by Doctors Daniel Blaine and John H. Baird of the Neuropsychiatric Division of the Veterans Administration and by Jack H. Stipe, Chief of the Social Service Division. According to Doctors Blaine and Baird, the Neuropsychiatric Division has adopted the policy of developing "a program of foster home care for selected psychotics and an extension of the trial visit program generally."[2]

* * *

Overall consideration of the materials and results of this study suggests the following recommendations, which are respectfully submitted:

The major development recommended is a family care program. The need for this would seem to be great, if the maximum of freedom and benefit are to be given the chronic patient, if certain administrative problems inherent in the provision of intramural care for large numbers of chronic mental patients are to be resolved, and if hospital costs are to be reduced.

While the provision within the Veterans Administration of special funds to provide for the costs of boarding home care would seem to be essential to the fullest utilization of this resource, the results of this

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[2] *Op. cit.*, p. 463-4. See Chapter III, p. 30, of this paper for fuller discussion; also Stipe, *op. cit.*, p. 52.

study would seem to indicate that such a program could be developed at the Bedford Veterans Hospital without the additional resource of special funds. Many patients--non-chronic as well as chronic--might be benefitted and many beds might be made available for the treatment of those more acutely ill.

The potential values of maintaining an active social service follow-up with chronic mental patients have been demonstrated in connection with several cases; and there is indication that some chronic mental patients could be placed in the community through such an approach--even without the development of a family care program. Such an active social service approach or follow-up is, therefore, felt to be desirable. However, the value and practicability of an active social service approach would seem to depend partially upon the extent to which the possibilities and potentialities of boarding home care can be utilized.

If an active social service approach to the problem of placing chronic mental patients should be continued, the development of an established procedure for the selection of such patients would seem highly desirable. A highly developed procedure was utilized in selecting the patients considered for placement by the Chicago State Hospital and is described in Florence P. Worthington's study, "Suggested Community Resources for an Extensive Parole System for Mental Patients in Illinois" (see bibliography). Other writers, such as Hester Crutcher, have suggested procedures that have been found effective more specifically in connection with family care.

Approved,

Richard K. Conant

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APPENDIX A

Schedule A

(To be applied to the total group of one-hundred cases.)

Name:...No............

Psychiatric diagnosis:...

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Age:.........

Military service:

World War I:.....World War II:.....Other..........................

Period of hospitalization for present illness:

At this hospital:.....yr......mo.

Total period of hospitalization for present illness:.....yr.

APPENDIX B

Schedule B*

Supplementary Information

(To be applied only to those cases selected for pre-trial visit planning.)

I: Identifying and General Descriptive Information:

Name: Number:

(Balance of such information to be obtained from Schedule A.)

II: Physician's Description of Illness and Recommendations:

Statement concerning present mental condition of the patient:

Have the above disabilities been of a static or progressive nature, or has the patient shown recent improvement?

Significant physical disabilities:

Requirements for care and supervision if placed in the community:

Specific recommendations concerning type of placement:

Recommendations concerning employment:

III: Additional Description of Patient's Attitudes and Behavior:

Attitude toward leaving the hospital:

Attitude toward accepting required supervision outside of the hospital:

Attitude toward his family, where a factor in pre-trial visit planning:

Attitude toward boarding home care, where a factor in pre-trial visit planning:

Adjustment on the ward and use of privileges:

Hospital work adjustment:

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*Condensed for inclusion here.

Past adjustment outside of the hospital on passes, leaves of absence, or trial visits:

General observations of the social worker concerning patient:

IV: <u>Social Worker's Evaluation of Family Resources and Family Attitudes</u>:

Was patient found to have one or more responsible close relatives?

If no such relatives were contacted, though known of, indicate why:

(Note: Answers are to be given in detail to the following questions, specifying separately all relatives' homes considered and the situation encountered in each home.)

Family attitudes toward accepting patient on trial visit:

Family's ability and willingness to give the required care and supervision (indicate factors affecting):

Description of other general attitudes and behavior shown toward patient and general emotional tone in the home, including worker's evaluation as to whether these factors were favorable or unfavorable to patient's adjustment:

Other factors considered as favorable or unfavorable to placement of the patient with the family:

Relatives' attitudes toward boarding home care, nursing home care, or any other type of plan (besides a placement with relatives) considered for patient:

V: <u>Financial Resources of Patient</u>:

Amount of disability compensation entitled to if placed in the community, where known:

Other income:

Approximate amount of estate, where known:

Was lack of sufficient financial resources a factor limiting the placement possibilities of the patient or otherwise an obstacle to pre-trial visit planning?

Where yes, describe specific manner in which trial visit planning was affected:

VI: Other Factors Favorable or Unfavorable to Pre-trial Visit Planning:

Where a significant factor in planning, indicate educational background, vocational background, or any other favorable or unfavorable factors not indicated above:

VII: Description of Social Service Activity and of Results Obtained:

Was the patient placed on trial visit?

Where yes, description of plan effected:

If the patient has not been placed on trial visit, has a plan been completed which, it is believed, will make placement possible within a definite time?

Where yes, description of plan completed:

If the patient has not been placed on trial visit and no satisfactory plan for placement has been completed, what obstacles to trial visit placement have not been overcome?

Where trial visit planning has not been concluded within the time limits of this study, describe contemplated social service activity and plans remaining under consideration: